OXFORD BROOKES UNIVERSITY

A Defence of Szasz's 'The Myth of Mental Illness' and its Relevance to Modern Mental Healthcare

MA by Research Philosophy

Catrin Elizabeth Street-Mattox

17060223

Director of Studies: Mark Cain

Second Supervisor: Daniel O'Brien

Oxford Brookes University – 2022

Acknowledgements

Abstract

This paper surrounds the discussion of Szasz's ideas regarding mental disorders from his publication 'The Myth of Mental Illness'. Not only are these ideas relevant today due to the mind-brain problem in psychiatry not being resolved, leading to varying ideas about the best practice in mental psychiatry, but also because of similar issues to those which inspired Szasz to suggest a new way to understand mental disorders still affecting mental healthcare service users today. Therefore, if Szasz's ideas can be proved as defensible against their most common critiques, I claim they could be of use to improve modern mental healthcare.

Specifically, I use hermeneutics to uniquely criticise Graham's argument from the *'In/Of'* Distinction, iterations of which have commonly been used to disprove Szasz's ideas. This critique not only disproves that the *'In/Of'* Distinction is enough to criticise Szasz, but also demonstrates the impact that our sociocultural context has on our expectations relating to mental disorders.

I then conclude that, due to failures in mental healthcare existing today that are similar to those present at the time of Szasz's writing, ideas from 'The Myth of Mental Illness' being defensible against their two main critiques, as well as hermeneutics re-enforcing Szasz's claims relating to the impact of an individual's background and experiences on mental disorders, Szasz's argument cannot sufficiently be dismissed. Therefore, ideas from 'The Myth of Mental Illness', along with key points from my novel argument of the '*In/Of*' Distinction through the consideration of hermeneutics could potentially be used to tackle issues facing modern mental healthcare.

Contents

Introduction

This paper aims to demonstrate why the ideas from Thomas Szasz's 'The Myth of Mental Illness' (1960) are defensible through a unique criticism of the *'In/Of'* Distinction, and why the key points from both this unique criticism and Szasz's original argument are relevant to mental healthcare today.

The first chapter of this paper begins with a brief overview of the 'Mind-Brain' Problem, introducing the key theories of The Medical Model and Dualism, as well as exploring their possible impacts on mental healthcare. Following this introduction to the 'Mind-Brain' Problem, it is highlighted how its lack of resolution has left academics to criticise the ways in which mental healthcare is carried out and argue for new ways to re-frame our understanding of mental disorders. The works of Szasz and Rosenhan are focused on, as they highlight the failures of mental healthcare in the mid-90s and demonstrate why a new understanding of mental disorders was needed. It is then established that there are similar failings in mental healthcare today, specifically in the United Kingdom, and that therefore the work of Szasz is still relevant to the mental healthcare landscape today.

Chapter two introduces Szasz's alternative understanding of 'mental disorders' from 'The Myth of Mental Illness' (1960). It is then explained how a defence of Szasz's ideas could potentially have a positive impact on mental healthcare. The two main arguments against Szasz's theory are then introduced: The Argument from Biology and The Argument from the *'In/Of'* Distinction. In chapter two the failure of The Argument from Biology is explained and critiqued, demonstrating why it is not a robust enough argument to disprove Szasz's key ideas. The Argument from the *'In/Of'* Distinction is briefly introduced before being explored in detail in chapter three.

Five common examples of the *'In/Of'* Distinction from Graham (2013) are introduced at the start of chapter three, the aim of them being to disprove Szasz's claims surrounding his re-understanding of mental disorders. However, it is then demonstrated that there is a flaw in the reasoning of the *'In/Of'* Distinction, which is highlighted through the discussion of hermeneutics. Therefore, instead of disproving Szasz's ideas, these criticisms actually lead the '*In/Of'* distinction to further support the ideas of Szasz.

The final chapter of this paper reiterates how Szasz's ideas from 'The Myth of Mental Illness' are relevant to the mental healthcare landscape today and cannot be disproved by either The Argument from Biology or The Argument from the *'In/Of'* Distinction. The potential impact of Szasz's ideas, combined with the unique criticism of the *'In/Of'* Distinction from hermeneutics, on mental healthcare are then briefly discussed, suggesting that there is

potential to address key issues highlighted by the latest review of mental health in the UK through acknowledging the impact of sociocultural context on mental health diagnoses (UK Government, 2018).

The conclusion of this paper highlights key ideas discussed throughout previous chapters. The lack of definitive evidence to prove that either the Medical Model or Dualism represents the true nature of mental disorders allows for academics to criticise various practices in mental healthcare depending on which theory they favour. Along with a lack of resolution to the mind-brain problem, failures in mental healthcare in the mid-90s caused writers like Szasz to suggest new ways in which mental disorders should be understood. The similarities between failures in mental healthcare at the time of Szasz's publication and today are demonstrated before criticisms of Szasz's argument are shown to be ineffective. The potential positive impact of re-framing our views of mental disorders through a lens that acknowledges sociocultural context, as inspired by Szasz, is then briefly explored before it is concluded that Szasz's ideas from 'The Myth of Mental Illness' are not only defensible and relevant today, but may also have positive impacts on mental healthcare.

Chapter 1 – The Mind-Brain Problem in Philosophy of Psychiatry

In the past 50 years, there has been significant and increasing interest in the value that philosophy can add to the practice of psychiatry and our understanding of mental health (e.g., Banner & Thornton, 2007; Broome, et al., 2004; Murphy, 2013). From helping patients, or 'mental health service users' (the term that I choose to use throughout this paper) to critically understand their illnesses, to reducing the stigma that mental health service users face, philosophy has recently made practical, positive contributions to psychiatry (Pulvermacher & Stammers, 2020). However, despite philosophy looking into various different realms of psychiatry, one fundamental question is still debated and, depending on one's resolution, would have significant implications on both our understanding and treatment of mental health: the discussion surrounding the nature of mental disorders. This is to question if the disorders that psychiatry concerns itself with are akin to those of other physical medical practices, like cardiology or osteology, or if mental disorders are, or are at least partially, removed from the physical.

The nature of the mind-brain is a key question that is debated in the field of philosophy of psychiatry. The Diagnostic and Statistical Manual of Mental Disorders (DSM) which seeks to lay guidelines for the diagnosis of mental disorders have prefaced their own definitions of 'mental disorder' with acknowledgements of inadequacy (American Psychiatric Association, 1994; 2013; 2022b). The challenge to define the term 'mental disorder' reflects an ongoing disagreement in psychiatric practice: a debate between those who see mental disorders as being reducible to neuroscience- physical problems in the brain, and those who reject this biological 'Medical Model' and instead look at social and cultural contexts of service users which can be seen to impact mental health in a 'dualistic' manner (Matthews, 2013).

The lack of resolution between proponents of the Medical Model and Dualism has led to debate regarding how mental health service users should be treated, what mental healthcare should look like and what the nature of a 'mental disorder' really is. Following serious failures in mental healthcare in the 20th century, some academics began suggesting new ways of understanding mental disorders, with the hope of improving the care of service users. Today, there are still serious failures in mental healthcare and no resolution to the 'mind-brain' problem. Therefore, I argue that these ideas of re-framing mental disorders, specifically the

work of Szasz (1960, 1972, 2011), should continue to be considered and explored with regard to improving mental healthcare today.

1.1 The Dualist View of the Mind-Brain

The term 'dualism' in Philosophy can be used in many different areas and designates the understanding that there are two parts to something. In the case of psychiatry, we can look at the dualism of the mind-brain. We generally accept that humans have both mental qualities such as kindness, confidence and tenacity, and physical qualities, such as height, weight and strength. Dualism argues that these mental qualities, those related to the mind, and these physical qualities, those related to physical matter, including the brain, are "distinct and independent substances" (Matthews, 2013, p. 531). When considering mental disorders, if the dualist sees the 'mental' and the 'physical' as two distinct parts, the question arises of 'where' do mental disorders take place? Are they found in the physical matter of the brain, in the non-physical 'mental' mind, or is it possible that they can affect both distinct substances simultaneously?

The opposing view to dualism is 'materialism'- the view that mental and physical properties are "identical" and are therefore actually the same one 'substance' (Matthews, 2013, p. 531). Dualism then, must not only 'decide' whether they see mental disorders as occurring in the physical or the mental (or both), but also overcome the challenge from materialism: that mental disorders just belong to one substance that embodies what they consider to be 'physical' and 'mental'.

The DSM-IV was seemingly clear in its stance on dualism- apologising for the term 'mental disorder' used in its own title, as it could suggest a distinction between mental and physical substances that is a "reductionist anachronism" of dualism (American Psychiatric Association, 2000, p. xxx). The DSM-V however seems less clear in its stance on dualism, stating that mental disorders are the result of "dysfunction in the psychological, biological, or developmental processes underlying mental functioning", but making no claims about whether such dysfunctions or processes are physical (American Psychiatric Association, 2013, p. 20). Here we see that the DSM has retracted its clear dismissal of dualism, and although it does not definitively adopt a dualist perspective, it does give mental disorders the option to be caused by psychological (mental) or biological (physical) processes, and does not claim that these processes are the same, or that both must be present for the diagnosis of a mental disorder.

Graham (2010) argues that the diagnostic criteria contained within the DSM, such as 'low self-esteem', 'childlike silliness' and excessive emotionality', suggests that mental disorders are deviations from "satisfying or prudent personal activity", something that is based on

subjective mental interpretation and feelings, not on the identification or existence of any physical dysfunction- something that can be considered as 'subjective'. Therefore, rather than implying that there is a lack of "healthy and proper brain function", or dysfunction somewhere in the physical brain, the diagnostic criterion of the DSM can be seen to suggest that diagnoses of mental disorder are based on how an individual feels or how others feel about them, something that can be seen as wholly mental (Graham, 2010, p. 54).

Before continuing, it is important to understand what is meant by 'objective' and 'subjective' in this context, as these claims relating to mental disorders will appear throughout this paper. The claim that a diagnosis of a biological dysfunction is 'objective' is to say that there is a fact of the matter which is independent of judgement. For example, I may say that the capital of Australia is Canberra, but someone may argue with me and claim that it is Sidney. Through research, we can find that the fact of the matter is that Canberra is the capital of Australia. I was right and the other person was wrong, and this fact is independent of judgement. In the case of physical illness, independent of a clinician's likes or dislikes, or any other judgements, the service user either has a biological dysfunction or they do not, which can be found through tests which reveal dysfunction.

In contrast, the claim that something is 'subjective' itself could be interpreted in different ways. We could see subjective judgements as those involving 'matters of taste'. For example, I might think that the best ice cream is pistachio because it is my favourite flavour, but someone else may say that chocolate ice cream is the best because it is their favourite flavour. These claims are subjective because they are matters of taste, there is no fact of the matter that is independent of judgement in these cases as they are based on personal preference. We could also see a claim as being 'subjective' if there is a lack of sufficient evidence to make the claim, or if that claim is itself based on wholly subjective evidence.

I believe that in the case of mental disorders, both interpretations are relevant. To start with the first interpretation, the diagnostic criteria for mental disorders themselves can be seen as subjective, which not only means they cannot be objectively tested for, but that decisions made about them are judgement calls. Just as the concept of 'favourite ice-cream flavour' exists, the concept of 'low self-esteem' exists, but just as our favourite flavour of ice cream is based on a sliding scale of flavours we like and flavours we dislike based on ones we have tried in the past, our views on the extent of 'silliness', 'sadness', or 'self-esteem' are also based on sliding scales which are influenced by our experiences and interactions with other people. If I had only ever met people who were extremely comfortable in themselves and had no real concern for body image, I may meet someone who puts make-up on daily and assume that they have extremely low self-esteem because they feel the need to change

their appearance. It is only when I meet more people that I understand that many people put on make-up daily and that there are people who are impacted so much more by low self-esteem they feel the need to do even more to tackle it. I cannot make an accurate judgement about the extent of someone's low self-esteem unless I know where on an everchanging scale it lies, just as I cannot make a definitive judgement about what my all-time favourite ice cream flavour is until I have tried every single one. Not only does this demonstrate the subjective 'matter of taste' nature of the DSM's diagnostic criteria themselves, but also how hard it is for a clinician to have sufficient evidence to make a claim of mental disorder diagnosis. In this way, it can be seen as an objective matter of fact that there, for example, are depressed people in the world, but clinicians make a subjective claim of diagnosis because of insufficient evidence and inherently judgement-based diagnostic criteria.

The subjectivity of the DSM's diagnostic criteria can also link to our second interpretation of 'subjective' and impact our perception of the diagnoses made by clinicians. If we accept that mental disorders exist and that people have them, these are matters of fact. For the purpose of this argument: mental disorders existing and people having them are objective facts. However, judgements relating to their diagnosis can be seen as subjective because clinicians may lack sufficient evidence to make these claims. There are no definitive tests for mental disorders as there often are with physical dysfunctions, we cannot test to detect diagnostic criteria of mental disorders such as 'child-like silliness' or 'low self-esteem' as we can for a mutated gene or a broken bone. Furthermore, the diagnostic criteria they do use for diagnoses are themselves subjective, as they can be seen as 'matters of taste'. Therefore, when a clinician makes a judgement about whether a service user has such symptoms, it can be said that they are doing without sufficient evidence as they are having to make a judgement about whether the service user's symptoms meet these already subjective diagnostic criteria without the use of definitive tests and are having to place the service user somewhere on an ever-changing 'sliding scale' based on previous experiences. These judgement calls can be seen to lack evidence, not only because there are no physical tests for the diagnostic criteria of mental disorders and because these diagnostic criteria are themselves subjective, but also because of the constraints these diagnoses are made under. The constraint of time and if it impacts diagnoses will be discussed in detail in section 1.4 of this chapter.

I have only mentioned the issue of subjectivity briefly for now as the discussion of diagnostic criteria being subjective in this way is a key focus in chapter three and is discussed in much more detail, using case studies and examples in section 3.2 of the chapter. However, I

believe it is important to address a possible misunderstanding of the subjectivity of the DSM's diagnostic criteria before we move on.

The claim that the diagnostic criteria of mental disorders are inherently value-based, and therefore subjective, as well as the claim that clinicians make diagnoses without sufficient evidence, causing them to be subjective, could suggest that it is necessary for mental disorders themselves to be considered as subjective. However, I do not believe that this is necessarily the case. We must consider what defines a mental disorder. Do the diagnostic criteria of the DSM define the nature of depression or are these symptoms just the American Psychiatric Association's best current theory about how depression manifests? If it is diagnostic criteria themselves which define the nature of a mental disorder, then mental disorders themselves could be considered as subjective, but I do not believe this is the case. Given that the diagnostic criteria and descriptions of mental disorders in the DSM change from edition to edition, I suggest that the current criteria are just the most recent theories about how a mental disorder presents and manifests, without making any claims about the nature of the mental disorder. Therefore, we can claim that the theory about the manifestation of a mental disorder may be subjective or incorrect, without claiming that the disorder itself is subjective or incorrect.

As well as claiming that mental disorder diagnoses are subjective, Graham (2010) also argues that the symptoms of brain diseases, such as Parkinson's which are biological dysfunctions of the physical brain, are more objectively recognised compared to the symptoms of mental disorders, which he interprets as being subjective. This viewpoint is also supported by Matthews (2013), in his exploration of dualism vs. materialism in The Oxford Handbook of Philosophy of Psychiatry.

Parkinson's Disease has physical indicators such as 'tremors' 'rigidity' and 'postural instability'. These symptoms, it can be argued, are objective "failures of the body to function in biologically normal ways" or ways in which are conducive to living a standard length of life for a species (Matthews, 2013, p. 573). In contrast, psychological and behavioural symptoms such as 'childlike silliness', 'depressed mood', 'obsessions' or 'excessive emotionality' are "subjectively experienced moods, thoughts, emotions […] or social[ly] abnormal patterns of behaviour" (ibid, p. 573). With a neurological disorder such as Parkinson's, a person may struggle to fulfil the activities they need to in order to live a standard-length life, such as exercising or escaping danger. In contrast, a person with a mental disorder may struggle to form healthy relationships, concentrate for long periods of time, or get up early in the morning, but this person's body is still physically able to allow them to lead a healthy and average-length life. However, the symptoms of a mental disorder may lead to 'choices' which

limit this lifespan. In cases of physical illnesses, whether they be neurocognitive or otherwise, such as Parkinson's or cancer, "the disease itself directly causes death", and although people with depression may be "more likely" to die than those without it as they have a higher rate of suicide, it is not the depression itself that causes the person's death, but the person's actions as a result of the depression (ibid, pp. 537-538).

I am not wholly convinced by Graham's and Matthews' reasoning about the contrasting objectivity and subjectivity of symptoms of brain disorders and mental disorders, as I believe that the physical indicators of a brain disorder such as Parkinson's can still be seen to be subjective, just as it is argued that indicators of mental illness are. If a previously healthy young person began to experience 'postural instability' and 'rigidity', it could generally be assumed that we would see there as being something 'wrong' with this person, because we don't expect someone who is young and has been previously healthy to be experiencing these symptoms. However, if we saw a very elderly person with these physical symptoms, we may just assume that these are just a part of ageing, and it may be more surprising to us if a very elderly person did not experience these physical symptoms. Here we can see that, just as 'childlike silliness' or 'depressed mood' can be seen as 'abnormal' behaviours when based on our subjective social norms and societal expectations of people, physical symptoms can also be seen as 'normal' or 'abnormal' depending on our expectations of an individual, in this case, our expectations of young and elderly people.

Although I do not think Graham's and Matthews' claims about the contrasting objectivity and subjectivity of symptoms and indicators of physical and mental disorders are entirely convincing as an argument for a dualist view of mental disorders (or at least for not ruling out such a view). I do believe that they raise an important point about the distinct differences that I see there as existing between the diagnostic criteria of mental disorders and disorders which can be biologically proven to be physical dysfunctions of the brain. There is a clear difference between the objectivity and subjectivity of the physical diagnostic criteria, such as that used for Parkinson's, and the symptomatic diagnostic criteria used for mental disorders in the DSM. Brain diseases, like Parkinson's, Alzheimer's, Frontotemporal lobe degeneration, Prion disease, Lewy Body dementia, and many others mentioned in the DSM-V, are diagnosed through objective physical tests, such as MRI scans, detection of misfolded proteins or identification of certain genes. These tests, and therefore the diagnoses of these disorders are objective; the MRI scan either does or does not show a physical indicator of biological dysfunction, misfolded proteins and particular genes are either biologically present or not. In this way, the diagnoses of such brain dysfunctions are objective, they either exist as a matter of fact or they do not. The need for these tests might be brought about because a service user is experiencing symptoms such as 'postural rigidity' or 'tremors', but these

symptoms are not enough alone for a diagnosis of physical brain dysfunction, objective tests must be carried out. In contrast, the diagnosis of mental disorders rests on clusters of symptoms alone. If we are assessing whether someone is displaying 'childlike silliness' or 'excessive emotionality', we have no objective tests to aid us, our assessment is made solely on our subjective interpretation of the service user. Similarly to how we may see it as normal for an elderly person to experience instability or rigidity, but see it as abnormal for an otherwise healthy young person to experience these symptoms, we may see it as being 'normal' for someone who had just gone through a traumatic experience to have a 'depressed mood' or display 'excessive emotionality', but displaying these symptoms as a person who is leading what we perceive to be a generally happy and fulfilling life could be seen as abnormal.

Admittedly, the DSM-V does attempt to include some form of safeguard to avoid socially accepted reactions being medicalised when it states that "an expectable or culturally approved response to a common stressor or loss" should not be classed as a mental disorder (American Psychiatric Association, 2013, p. 20). However, when at least 1 in 4 people in the United Kingdom experience a mental health disorder, how are we to say that symptoms of mental disorders are unexpected or unacceptable (McManus, et al., 2016)? Furthermore, when over 15% of clinicians in the UK report as identifying as a different nationality, suggesting that a number of these professionals will be from a different social background from the service users they are treating, how can we expect clinicians to know precisely what should be deemed as culturally acceptable and approved (Baker, 2021)? This claim itself also contains the assumption that as a country, people of the UK hold similar views regarding mental disorders, which itself has been shown to be untrue, with some people seeing different disorders as being 'more' or 'less' serious than others, a variety of thoughts about the 'causes' of mental disorders, along with different views about how much a mental disorder needs to 'effect' someone to be considered a 'mental disorder' (Arnot, et al., 2021). Taking these statistics into account, I still believe that the interpretation of symptoms of mental disorders, along with the judgment of whether they are 'socially accepted' or not are both highly subjective judgments, that are made with a lack of sufficient evidence due to the nature of the diagnostic criteria from the DSM and the time in which clinicians must make diagnoses. This discussion of subjectivity and objectivity being reliant on interpretation which is impacted by sociocultural context becomes key in the third chapter of this paper when the extent of the impact of these judgements on our understanding of mental disorders is discussed in more detail. In this way, we can see that there is a clear contrast between the diagnostic criteria of mental disorders and physical disorders,

suggesting that there is a separation between our physical bodies (including our brain) and our mentalities, as suggested by dualism.

The distinction between physical brain diseases and mental disorders is further exemplified in the DSM-V's section focussing on Neurocognitive disorders. When diagnosing neurocognitive disorders, clinicians need to specify whether they are mild, or major, as well as what physical disorder of the brain they are caused by, whether this is Alzheimer's, Huntington's, Parkinson's, Lewy Body disease, HIV infection etc. (American Psychiatric Association, 2013, p. xxx). These conditions are different to others in the DSM-V, such as depression, bipolar or OCD, as neurocognitive disorders have an underlying biological cause that is required for them to be diagnosed, unlike other conditions in the DSM which are wholly diagnosed by symptoms alone. In this way, neurocognitive conditions are almost a 'symptom' of biological dysfunction themselves, as they cannot be diagnosed without at least one biological dysfunction having already been identified. Also included in the diagnostic criterion of neurocognitive disorders is the qualifier that these conditions must not be better explained by a different mental health condition (American Psychiatric Association, 2013, pp. 645- 684). This distinction implies that mental disorders and neurocognitive disorders (which must be caused by physical dysfunction) are separate types of disorders, and although both can affect behaviours, social conduct, emotionality etc., the diagnostic criteria for neurocognitive disorders dictate that there must be an underlying biological dysfunction already diagnosed, unlike other mental disorders in the DSM whose diagnostic criteria are symptomatic alone. This further suggests that there is a distinction between conditions that are caused by physically identifiable biological dysfunctions and those which are not, as suggested by dualism.

In this way, we can see that the DSM allows dualism to have a place in psychiatry, through its retraction of its outright rejection of dualism from the DSM-IV to the DSM-V, the perceived objectivity and subjectivity of physical vs mental symptoms, which can be seen to imply a dualist perspective, as well as dualism seemingly being implied by the diagnostic criteria used by the DSM-V.

Next, the contrasting Medical Model will be explored, leading us to the understanding that the mind-brain problem is not resolved and how it is therefore one of the reasons why academics like Szasz have promoted alternative views of mental disorders.

1.2 The Physicalist view of the Mind-Brain: Minimal and Hard Interpretations of the Medical Model

The Medical Model understanding of the mind-brain advocates that professionals in the field of psychiatry should 'consistently apply' "modern medical thinking and models" to their

understanding of mental disorders (Black, 2005, p. 3). This 'modern understanding' of medicine is generally believed to base new practice to improve health on the best possible evidence available (Murphy, 2013). For Murphy (2006) this 'best evidence' relies on a "neurological" and physical understanding of "diseased entities" including the brain (p. 10). However, proponents of the Medical Model fall into two groups based on their interpretation of this broad understanding. The difference in interpretation relates to how intrinsic this 'modern understanding' of medicine is to a mental disorder- whether it simply informs us of how to recognise and treat mental disorders or whether it suggests more about the nature of mental disorders themselves.

The minimal interpretation of the Medical Model does not make claims relating to the nature of mental disorders or any illnesses. Instead, it advises only on how we can recognise and tackle mental disorders. The minimal interpretation claims only that diseases should be understood as the "observable, regular unfolding of a suite of symptoms", and does not comment on how these symptoms occur or what causes them (Murphy, 2020, Online). This understanding of mental disorders can be seen to mirror the understanding used in the DSM, which specifies that the diagnostic requirements for mental disorders are based on the collection of symptoms a person experiences, rather than the detection of any underlying cause (American Psychiatric Association, 2013). Although the DSM-V does not require detection or understanding of any underlying causes of mental disorders for diagnosis or treatment (excluding neurocognitive and medication-induced disorders), their definition states that the symptoms people experience should be understood as reflecting a "dysfunction in the psychological, biological, or developmental processes" that impacts mental functioning (American Psychiatric Association, 2013, p. 20). This definition again, like the minimal interpretation of the Medical Model, makes no solid claims about the nature of mental disorders, it only acknowledges that there is an underlying cause of some form. Similarly, McHugh and Slavney (1998) argue that mental disorders should be diagnosed from clusters of symptoms and that these diagnoses should then be used as starting points to explore the underlying physical causes of the disease, but the understanding of these underlying physical causes are not required for diagnosis or treatment.

In practical terms, the minimal interpretation can be seen to advocate for empirically evidenced-based treatments- acknowledging that collections of particular symptoms often react in certain ways to different dosages of medication, even if the cause of these symptoms is not known. Although the minimal interpretation of the Medical Model may use medications as treatment, just as modern medicine treats many physical disorders, the interpretation makes no claims about "what is really going on with the patient" to cause their symptoms (Murphy, 2013, p. 967).

In contrast to the current edition, the DSM-IV seemingly had a much stronger view about the underlying causes of mental disorders, stating that it was "unfortunate" that the term mental disorders implied that there was "a distinction between mental and physical disorders" which, as we have already discussed, could be seen as dualism. The DSM-IV rejected any form of dualism in which the mind and brain could be separate, stating that there is in fact "much 'physical' in 'mental' disorders" (American Psychiatric Association, 2000, p. xxx). This older definition from the DSM could be interpreted as more 'forward looking' compared to its successor. This is because its claims surrounding the physicality of mental disorders can be seen to suggest an understanding of psychiatry similar to that of Hempel (1965), who predicted that as the study of psychiatry progresses, it will develop a system of diagnoses based on an understanding of the "objective nature" of mental disorders, rather than their symptoms (Murphy, 2020, Online). This prediction suggests that mental disorders will, in time, be diagnosed in a similar way to physical illnesses, by objective results from tests and measurements, rather than by groups of symptoms. This previous definition from the DSM can be seen to link more closely, although not completely, to the hard interpretation of the Medical Model, which does make claims about the nature of diseases.

The hard interpretation of the Medical Model states that all diseases can be reduced to biology, including mental disorders. Just as physical disorders can be traced to malfunctions in various bodily systems, for those who agree with the hard interpretation of the Medical Model, mental disorders can be reduced to physical dysfunctions which are responsible for the "patterns of (…) symptoms" that occur (Murphy, 2013, p. 967). Where the DSM and the hard interpretation of the Medical Model diverge is the importance of these underlying causes- the DSM-IV simply acknowledged these underlying physical causes, and the DSM-V only suggests that such physical dysfunctions could be possible causes, whereas proponents of the hard interpretation state that diagnoses rest on these causes, rather than on a collection of signs and symptoms, as is the case in the DSM.

Nesse and Stein (2012) argue that the hard interpretation is a more 'genuine' Medical Model as it "uses understandings of normal functions to categorize pathologies" such as is done when diagnosing physical ailments (p. 1). For example, when a patient has a cough, medical professionals understand the function of this symptom, in this case, it may be to clear the lungs for example, which "guides" them to the underlying malfunction that is causing the cough, such as the lungs having mucus in them, and this underlying cause is the basis of the diagnosis, a chest infection which produces mucus on the lungs (ibid, p. 1). Diagnosing physical diseases based on their underlying causes rather than their symptoms was a shift that occurred in 19th Century medicine, for physical illnesses. Yet over 30 years of searching for physical "biomarkers" for the causes of mental disorders have proved largely fruitless,

leaving proponents of the hard interpretation to search for an explanation as to why they cannot be found or if there are alternative proofs of physical causes available (ibid, p. 3).

Practically, the hard interpretation of the Medical Model (if adopted as a basis for diagnosis) would require an understanding of the 'normal' functions of the physical parts of the body responsible for mental health. This understanding of 'normal' functioning would then allow for the detection of 'abnormal' functionality, as indicated by symptoms. A diagnosis could then be made from physical causes of symptoms rather than symptoms themselves, as is the case for the minimal interpretation of the Medical Model.

1.3 The implications of the Mind-Brain problem for Psychiatry

We now have an overview of the two most contrasting positions in the Mind-Brain argument and although there has been no resolution and therefore academics still argue for both viewpoints, I believe their impacts on mental health service users are also extremely important to discuss. The way we define 'mental disorder' and our understanding of how these disorders develop and exist could significantly affect how we treat mental health service users. The practical impacts of these viewpoints will reveal additional reasons why there are still proponents of both positions and why there are suggestions for an alternative understanding of mental disorders that could build upon the positives from both viewpoints.

Dualism and Psychiatry

If we were to accept a dualistic view of mental disorders, some claim that a 'wall' may be created between physical medicine and psychiatry, which has the possibility of perpetuating stigma for those who work in the field as well as its service users (e.g., Glannon, 2020; Latoo, et al., 2021; Novick & Ross, 2020; Ventriglio & Bhugra, 2015).

The separation between mental health service users and service users of physical medicine can be seen to have existed since the separation of their care between general hospitals and mental institutions and asylums, a clear sign that physical disorders and mental disorders were considered as being "intrinsically different" because of a dualistic perspective (Latoo, et al., 2021, p. 2). For Latoo et al, this barrier, created by dualism, lead to a lack of "holistic" patient care, as service users with physical illnesses would not be able to access mental health treatment, and vice versa, even if a service user was experiencing co-morbidity, as the way they would be treated would be dictated by the institution they were in (ibid, p. 2). A complete separation between mental healthcare and physical healthcare could also further impact the funding for both areas. Latoo et al. argue that the funding for mental healthcare, including research and clinical services, would be even further reduced if it became separated from physical medicine, with psychiatry already being the "poorer" of the two areas due to dualism not yet being wholly rejected (ibid, p. 2). Ventriglio and Bhugra

(2015, p. 369) similarly blame dualism for the 'funding crisis' they claim is affecting Western psychiatry, with the separation of physical and mental healthcare being to blame for psychiatric resources 'lagging behind' those of physical healthcare.

An acceptance of dualism may also impact the way mental health service users are viewed, as well as how their treatment is formatted. Latoo et al. (2021) argue that, in some cultures, mental illnesses are seen as 'mystical' because of the understanding that they are removed from physical illnesses. Therefore, rather than being traced back to a physical malfunction in the body, mental illnesses can be blamed on "witchcraft, magic or possession" (ibid, p. 2). This could potentially open up the possibility of a variety of people offering an "expert opinion" on how to treat, prevent and cure mental disorders, despite having no medical training (ibid, p. 2).

As well as opening up the possibility of unqualified people attempting to treat mental disorders, it is also claimed that dualism could mean that mental health service users are expected to solve their problems for themselves, which could result in a lack of sufficient mental health provision. If mental disorders become seen as illnesses that are 'all in the mind', then the individual who has the mental disorder could be seen as responsible for "resolving or avoiding" mental disorders, as the mind, and therefore mental disorders may be seen as things that are within our "conscious control" (Glannon, 2020, p. 2). This perspective could increase the stigma faced by mental health service users as they may be seen as being 'to blame' for not conducting their minds in such ways that avoid or resolve mental disorders which involve feeling and acting in ways deemed as unacceptable or unusual by the society around them.

However, it could be argued that viewing mental disorders from a dualistic perspective shifts the 'power' from a medical professional and a biological 'disease' to the mental health service user. Philosophers such as Bentall (2004) argue that an understanding of mental disorders which does not reject dualism, such as the one featured in the DSM-V, allows people with mental illness to be viewed as "a whole person" that is facing "baffling problems" that also has the ability to overcome these problems. Rather than being viewed as a person with "abnormal brain chemistry or anatomical lesions" that can only be treated only medically- reducing the part that an individual can play their own care (p. xi). If a physical health service user has cancer, they could be seen as 'powerless' to fight such a disease, with their physical body having little power to fight the physical dysfunction and relying on a medical professional for treatment. In contrast, if we accept at least a form of dualism regarding mental disorders, we no longer need to view the mental health service user as 'powerless', as they needn't have years of medical training and prescription medication to

have some control over their illnesses, although they can still choose to be supported through these means. Having some control over their mind, rather than their physical brain, gives the service user power that they do not have if their disorder is seen as purely physical and medical. This can be seen to reflect how we often treat mental disorders in the UK today, through combination of therapies which enable the service user to personally make positive choices to improve their disorder, as well being complimented by medications prescribed by clinicians.

Although it can be argued that dualism provides more power to the service user in relation to their mental health disorder compared to a materialist perspective, if dualism were to be accepted in such a way that the mind and brain could not interact at all, it could mean that clinicians feel 'powerless' to help service users. If the only person that had power over their illness was the individual with the disorder, then clinicians may feel that they have no way of helping a service user that requests help. However, Chen-Wei Ng (2022) argues that this view of dualism is incorrect; we should not assume that the mind and brain being distinct substances mean that there can be no interaction between the two. Chen-Wei Ng admits that, for some, the philosophical question of how two distinct material and immaterial substances such as the brain and the mind can interact is enough for them to reject dualism. However, he suggests that this rejection should be reserved for philosophers, who are experts at arguing this either way and that medical and psychiatric professionals should not concern themselves with this metaphysical argument, as, for as far as their medical expertise are concerned, there is no "inherent conflict" between dualism and psychiatry (Chen-Wei Ng, 2022, p. 133). If clinicians reject a hard barrier between dualism and psychiatry, it could mean that they find the treatment of some service users more 'hopeful'. For example, if a mental health service user is seen as being made up but nothing other than what is purely physical, and the treatments they are currently undergoing seem to be fruitless, a clinician could become disillusioned with the treatment, as they may feel that there is no more that they can 'physically' do to treat the disorder. However, if clinicians were to accept that dualism can work within psychiatry, then there is more to a service user than just their physical body, there is something 'beyond' physical- the mind. Dualism allows clinicians to separate service users as individuals "from the neurological processes from which their difficult behaviours arise" (Chen-Wei Ng, 2022, p. 133). This could allow the clinician to see through the challenging behaviours the service user may be displaying and acknowledge that there is more to the person than their pathology. Once all physical medical treatments have been exhausted, acknowledging that there may be something beyond a service user's physicality may also mean that a clinician continues working with the service user in a more 'hopeful' way, knowing that more than just medications can impact their

mental disorder. Whilst Chen-Wei Ng (2022) claims this view is an acceptance of dualism working with psychiatry and neuroscience, those who argue against dualism, such as Glannon (2020), call this view non-reductive materialism- a situation in which states of the mind and states of the brain can, in some way, interact with and affect one another.

Practically, the dualist view of the mind-brain can be seen to allow for a more 'holistic' view of mental disorders. It not only focuses on the physical, biological factors that could cause mental disorders but also takes into consideration how our interactions with the world around us can affect our mental health. This could possibly lead to a more 'person-centred treatment of service users, with them having at least some form of 'power' to help combat their mental disorder. Seeing a mental health service user as having a condition that is more than just purely physical may also diminish instances of clinicians becoming frustrated when purely medical treatments do not work. However, it could also be argued that a dualist view of the mind-brain when applied to psychiatry could create a 'wall' between mental and physical healthcare, leading to a lack of access to each different service, as well as the increasing stigma that mental health service users face.

The Medical Model and Psychiatry

Rejecting dualism and understanding mental disorders through the Medical Model has been argued to make the treatment of service users easier for clinicians. Novick and Ross (2020) use the example of a heroin addict to exemplify their two main claims for the usefulness of the Medical Model for clinicians. A heroin addict often visits a hospital and is well-known by staff as being 'un-cooperative', 'manipulative' and 'pathological' and often asks for pain medication when their pain has no 'identifiable' physical source. Novick and Ross claim treating service users like this can be extremely demanding for clinicians, not just because of the service user's challenging temperament but because medical professionals can often feel 'stuck' for what treatment to provide if the service user's problems are dismissed as 'being all in their head'. For Novick and Ross, dualism allows for the explanation that symptoms can be 'all in the head' of a person, which is frustrating for both service users who may not receive the care they need, and clinicians who may feel 'stuck' for what treatment to provide.

However, if mental disorders are viewed through the lens of the Medical Model, it can help clinicians view service users' symptoms as conditions that are "within their scope of practice", as they are to some extent physical and can therefore be affected by physical treatments that clinicians are most familiar with (Novick & Ross, 2020, p. 329). Furthermore, understanding a service user's challenging outbursts as symptoms of a medical condition, rather than as something removed from their physical body, Novick and Ross claim, will

"invite empathy, to promote continued inquiry and discourse", removing some of the negative thoughts a clinician might feel towards an un-cooperative service user compared to if their behaviours were viewed as being 'all in their head' (ibid, p. 329). This is because an acceptance of the Medical Model would require the realisation that whilst a condition may be 'in a service user's head', "it is a head which houses the body's most complex organ"; the brain (ibid, p. 329). Therefore, rather than mental disorders happening somewhere 'outside' of our physicality, the Medical Model can be seen as 'locating' mental disorders in the brain, an organ which can malfunction like any other. In this way, it can be seen that the Medical Model may promote better treatment for service users and empower clinicians where they may have previously felt 'stuck'.

It has also been claimed that an acceptance of the Medical Model may decrease a person's responsibility for their actions. For example, if a person with epilepsy was to have a seizure which resulted in them knocking over a glass, we would not hold that person responsible for the glass breaking. This is because the individual has no control over their seizures, it is the 'fault' of the epilepsy, something which acts externally to the person's will. Blaney (1975) explains that, similarly, people with mental disorders could be seen as not responsible for their thoughts, feelings and behaviours if we were to adopt the Medical Model. This is because, just like the person's seizure was as a result of epilepsy, symptoms of mental disorders are as a result of the condition itself, something that is once again external to a person's will.

To a certain extent, and in extreme cases, we can see the impact of this view on our legal system. The 'Insanity Defence' from the Criminal Procedure Act of 1964 allowed a person to be found 'not guilty' of criminal charges brought against them on the grounds of insanity. The individual claiming to be 'insane' must be so in such a way that they are either unfit to plead, they need to be detained in a mental hospital before a trial has taken place, or they were 'insane' at the time of the offence, which meant they did not know what they were doing or did not know that their actions were 'wrong' (HM Government, 1964). Blaney also states that viewing mental disorders in a similar way to physical illnesses means that those who have them, including those who commit criminal actions, may face reduced stigma from society, as disorders classed as illnesses carry 'less shame' than something which is considered purely 'emotional' (Blaney, 1975, p. 913). Admittedly, Blaney was writing in the 1970s, and public perception of mental health can be seen to have developed significantly since this time, despite the 'Medical Model' not being fully proven or wholly accepted (Venters, 2018). Although our views of mental disorders have developed since the time of Blaney's writing, there is still of course significant stigma related to mental illnesses when compared to

physical illnesses (e.g., Henderson, et al., 2020; Rössler, 2016; UK Government, 2018; World Health Organisation, 2022).

Blaney's thought that the physical pathologicalisation of disorders reduces stigma can be argued against by looking at the changing views of homosexuality. Homosexuality, which was pathologized until 1973, can be seen to have become less stigmatised after it was no longer declared to be an illness (Park & Rhead, 2013). Although this is certainly not to claim that the LGBTQ+ community face no stigma today, only that the stigma faced has in some ways reduced since homosexuality was not considered as an illness over the past four decades. For example, only 11% of the British population saw homosexuality as 'not wrong at all' in 1983, compared with 47% of the population in 2013- this does not in any way claim that there is no stigma faced today, only that there is an apparent reduction in the number of people who hold this stigma (Park & Rhead, 2013, Online). This decrease in stigma is unlikely to be due to the de-pathologizing of homosexuality alone, however, and rather due to a combination of many different factors affecting the views of society.

However, when we think of 'illnesses' we often think of conditions such as cancer, asthma, heart disease etc., all conditions that we seek 'treatment' and 'cures' for. Although it may not be our fault that we are ill and experiencing symptoms, illnesses are generally considered to be states that we wish to 'fix'. Therefore, the de-pathologizing of homosexuality meant that it may no longer be seen as something to be 'fixed' (Drescher, 2015). Viewing mental disorders in this way, by rejecting the Medical Model and de-pathologizing them, may similarly mean that service users face less stigma as their disorder is not something that is considered to need 'fixing'. However, viewing mental disorders in this way may reduce the funding of mental health care and support, as if mental disorders were no longer considered an illness, why would we fund their treatment? It may also mean that people who do find their mental disorder distressing are unable to find support or feel further stigmatised as they cannot accept their disorder, even if it is not classed as an illness.

It can also be argued, in somewhat of a defence of dualism, that treating mental illness biologically, like physical illnesses, as per the understanding of the Medical Model, focuses only on the proximal cause of the mental disorder and disregards the distal causes. Proximal causes are the occurrences that directly affect an individual. For example, I am looking at a cup. This cup in front of me in the world is the proximal cause of me seeing the cup. The distal cause relates to my experiences of the proximal cause by indirectly affecting it. In this case, the sunlight bouncing off the cup and being sensed by my retinas is the distal cause, as without it I could not experience the cup that was in front of me. In terms of mental disorders, ignoring the distal causes could be seen as detracting from the social factors that

contribute to a person's mental disorder which could result in a failure to address injustices in society.

For example, Bluhm (2011) rejects a purely biological explanation for mental disorders, regarding specifically depression in women, and argues that the higher risk of depression in women is contributed to by the "particular attitudes and coping styles" that women adopt when socialising in society, based on their previous experiences socialising, and how society has treated them historically (p. 84). Similarly, Ussher (2011) discusses modern "female-maladies", such as anorexia, borderline personality disorder and post-traumatic stress disorder, which are diagnosed predominately in women (p. 11). Ussher argues that just as women in the 19th century were diagnosed with 'hysteria' as a result of experiencing "distress or debilitating fatigue in response to an oppressive and restrictive social or relational context, or more specifically, to violence and sexual abuse" the same can be said for women being diagnosed with some mental illnesses today as some psychiatrists continue to 'pathologize' "women's reasonable response to the material inequities of their lives", rather than understanding their 'struggles' as a reasonable reaction to the challenges they face and instead tackling these inequalities (ibid, p. 11).

In these examples, the distal causes of the mental disorders which disproportionally affect females are the ways in which women have been, and are, treated in society. The lived experience of injustices that females face has indirectly impacted their mental health in such a way that when they experience a proximal cause of a mental disorder, an immediate vulnerability or stressor, they react in a way which is labelled by some as a mental disorder, because someone who may not have experienced the same distal causes may have reacted in a different way which could be considered as more 'acceptable' if we were to not take into account the impact of distal causes.

Ignoring distal causes and focusing only on proximal causes in this way, as can be seen as a result of adopting the Medical Model in psychiatry, could not only be seen as trying to diminish the impact that social injustice can have on individuals but also to be 'shifting' the burden of treatment or recovery. This shift from a change in attitude and action being needed from a community to address injustices and inequalities, to the individual having to 'cope' with unjust treatment as their way of coping has been labelled as a 'disorder'.

Practically, adopting the medical model could be seen to ease the challenge of treating uncooperative service users for clinicians, as well as empowering clinicians to feel like mental illnesses are within their scope of expertise, as well as reflecting our legal system in terms of the use of the Insanity Defence' from the Criminal Procedure Act of 1964. However, it can also be argued that the adoption of the medical model could lead to a lack of

acknowledgement of how much society affects mental health, possibility pathologizing reasonable reactions to injustice.

1.4 Why We Still Need to Question Psychiatric Practice Today

The lack of a definitive standpoint from the DSM-V regarding dualism vs the Medical Model has left mental disorders open to being viewed dualistically or materialistically. With there being no certainty about the nature of mental illnesses when compared to physical illnesses due to this ongoing mind-brain problem, the practice of psychiatry has been left open to criticism, with practices that more closely match the Medical Model being criticised by those who adopt a dualist perspective and vice versa. As well as arguments that neither is the correct way to view mental disorders being suggested.

Despite the experiment taking place in the 1970s, many philosophers and psychiatrists still refer to Rosenhan's 1973 study 'Being Sane in Insane Places' to advocate for further research into the hard interpretation of the Medical Model (e.g., Nesse & Stein, 2012; Novick & Ross, 2020) and others to support the anti-psychiatry movement, often related to Foucault (1965) and Szasz (1972). Both Szasz and Rosenhan advocated for drastic improvements to mental healthcare, however, it is worth noting that although his position has often been related to the anti-psychiatry movement (e.g., Caplan & Williams, 2012; Roberts, 2006), it is instead coercive and discriminatory psychiatric practices that Szasz argued against and began to write disapprovingly of around 10 years before Rosenhan's study. Szasz, his view of psychiatry and suggestions for a new way to view mental disorders, will be the focus of the further chapters of this paper once we have justified why they are still relevant today.

Rosenhan's experiment involved eight healthy "pseudopatients", including himself, who presented themselves to psychiatric hospitals along the East and West Coasts of the USA claiming they were having auditory hallucinations of the words: 'thud', 'empty' and 'hollow' (Rosenhan, 1973, p. 251). All of Rosenhan's patients falsified their names and employment details but answered questions about the rest of their personal history truthfully, meaning that details about their relationships with family, friends and partners for example were relayed accurately to admissions staff. Seven of the patients were then admitted to a psychiatric ward with a diagnosis of schizophrenia, whilst one patient was admitted with a diagnosis of manic-depressive psychosis. Once admitted, the patients all acted 'normally', as they would in day-to-day life, and told medical staff that the voices had stopped. Despite this, the length of time spent in hospitals by the pseudopatients ranged from seven to 52 days, with an average stay of 19 days. Three patients who were discharged after the least amount of time in their first hospital then went to other institutions, all three of which were once again admitted with a diagnosis of schizophrenia. All patients initially diagnosed with schizophrenia

were also released from hospital with a new diagnosis of 'schizophrenia in remission', rather than being 'cured' of the disorder they were initially admitted with (ibid, p. 254). Despite all of the pseudopatients in the experiment falsifying their symptoms, being truthful about their personal past, telling medical staff their symptoms had subsided almost immediately after being admitted, and acting normally once on the ward, in all nine attempts at admission, patients were admitted to psychiatric wards, given a diagnosis, medication and then released with a new diagnosis that did not reflect a lack of mental disorder or an acknowledgement of 'sanity', but a mental disorder "in remission" (ibid, 252).

In a follow-up study by Rosenhan, a psychiatric hospital was contacted and told that pseudopatients were being sent to them to seek admission. Staff were to rate patients seeking admission on a scale of one to ten, with one being 'highly likely to be a healthy pseudopatient' and ten being 'highly unlikely to be a healthy pseudopatient' (Cummins, 2017). Over 21% of the 938 patients seeking admission to the hospital were given a score of one or two by admissions staff, meaning they believed that these service users were highly likely to be pseudopatients. Contrary to Rosenhan's statement to the hospital, however, and despite admission staff believing that almost a quarter of people seeking admission were 'very likely' to be healthy pseudopatients, no pseudopatients were actually sent. It is important to note that there is no comparison between admissions staffs' views of service users before they knew that there was a possibility of pseudopatients attending their facility. For example, over 21% of service users seeking admission could have been turned away or have aroused suspicion on average every month, even before the hospital was contacted and knew that pseudopatients might be sent. There is no mention of this consideration in Rosenhan's papers, and seemingly not in his critics' investigations into his papers either (e.g., Abbott, 2019; Ruffalo, 2019; Spitzer, 1975). However, although I think it is highly unlikely that admissions staff were suspicious of such a high percentage of service users seeking admission, I believe it is still important to note this potential 'issue' before moving on to discuss the conclusion drawn from Rosenhan's experiment.

Rosenhan concluded that if psychiatric professionals could not detect sane pseudopatients, whilst also believing that over 21% of their legitimate service users were pseudopatients, then the psychiatric diagnostic process "cannot be a very reliable one" (Rosenhan, 1973, p. 252). It is also interesting to note that whilst all pseudopatients presented with the same symptoms, only one of the 12 admissions was diagnosed with "manic depressive psychosis", with the rest being diagnosed with schizophrenia. This one diagnosis came from the only completely privately funded hospital in the study (ibid, p. 258). When compared to the long-term prognosis of schizophrenia at the time, manic depression had a much more favourable outlook. Rosenhan suggests that not only does this indicate the unreliability of mental

disorder diagnosis, if service users with the same symptoms can receive differing diagnoses, but that a pseudopatient at a privately funded hospital receiving a more 'favourable' diagnosis suggests that there is a relationship between "social class and psychiatric diagnosis", affirming further that such diagnoses are not objective (ibid, p. 258).

Despite their apparent inaccuracy, Rosenhan notes that these psychodiagnostic labels are particularly 'sticky' ones, as demonstrated by the pseudopatients not losing their labels of 'schizophrenia' even when being discharged from institutions (Rosenhan, 1973, pp. 252-253). Despite all pseudopatients making clear that their symptoms had subsided as soon as they were admitted, outwardly acting 'sane', as made clear by nurses' notes which stated that the pseudopatients were "friendly, cooperative, and exhibited no abnormal indications", none of them were ever seen as being without a mental disorder from the moment they were diagnosed with one (ibid, p. 179). For example, the pseudopatients made extensive notes about their stays in their respective institutions, three of the pseudopatients' nurses' notes mentioned that their habit of writing was seen as a "behavioural manifestation" of their "pathological (…) disturbance" (Rosenhan, 1973, p. 253). Even a relatively normal activity, such as writing, can be seen as a sign of mental disorder if that 'label' has been previously attached to that individual. For Rosenhan, this demonstrated the 'power' that a psychiatric professional's initial diagnosis of a mental disorder has, causing the pseudopatients' normal, behaviours to be "overlooked entirely or profoundly misinterpreted" by the staff seeing pseudopatients daily in the hospitals (ibid, p. 253).

Rosenhan admits that it may be common for clinicians, in any field, to "err on the side of caution", especially during initial diagnosis, as it is better to "suspect illness among the healthy", rather than to miss what could be a potentially life-threatening disorder (Rosenhan, 1973, p. 252). However, whilst this may be preferred for physical illnesses, erring on the side of caution in psychiatry, and allowing 'sane' patients to be diagnosed with mental disorders, can be seen as extremely detrimental. Although it is far from ideal to receive an incorrect diagnosis or to lack a correct one, the issue of pseudopatients being undetectable by psychiatric professionals is made worse due to the treatment received once being 'labelled' as having a mental disorder. The pseudopatients were sent to a total of 12 different hospitals, with a range of institution ages, staff-to-service user ratios, research and treatment focuses, and funding types (11 being federal, state or university funding, one being completely private), in an attempt by Rosenhan to be able to 'generalise' the treatment of mental health service users in the USA (Rosenhan, 1973). A diagnosis of mental disorder comes along with stigma, stigma that was experienced in the 1960s at the time of Szasz's writing, continuing to the 1970s during Rosenhan's experiment, and that continues to be experienced today by mental health service users (Rössler, 2016). If, as demonstrated by

Rosenhan's experiment, it is extremely hard for a diagnosis of a mental disorder to be 'removed' or 'revoked', whether due to a lack of 'cure' or initial misdiagnoses, then a person who has been seen as having a mental disorder at any point, it can be inferred, may experienced stigma throughout their life.

It could be argued that people with physical health disorders also face stigma in society, and perhaps this stigma is simply on par with what mental health service users face. The problem with this argument is that, even if it is true, we are accepting that stigma for one group of service users is simply okay because another group of service users experience it too. We would never claim that racism towards one ethnicity was acceptable just because other ethnicities faced prejudice too. Whilst we cannot eradicate all stigma at once for all service users, just as we cannot eradicate all racism for all ethnicities all at once, it does not mean that we should accept the derogatory treatment of any group and make excuses for not finding a way to reduce unfair treatment.

Furthermore, the experiences of service users inside mental health institutions reported by Rosenhan's pseudopatients raise concerns regarding the treatment of service users by medical professionals once they have been diagnosed with a mental health disorder. At the hospitals that were visited by pseudopatients in Rosenhan's experiment, interactions between pseudopatients and hospital staff were recorded, specifying the duration (at six of the institutions) and the form of contact that occurred (at four of the institutions). When pseudopatients initiated contact with staff, ensuring to approach the same member of staff no more than once a day, they did so with a question formatted in a similar way to the following: "Pardon me Dr/Mr/Ms X, could you tell me when I [am eligible for grounds privileges]/ [will be presented at the staff meeting]/ [am likely to be discharged]?" (Rosenhan, 1973, p. 255). From 185 questions asked to Psychiatrists, only 4% of the time would the clinician stop and talk to the pseudopatient to answer their question. Most commonly, 71% of the time, the clinician would continue walking with their 'head averted' as if the pseudopatient had not been there. Similarly, with nurses and attendants, 88% did not engage with the pseudopatients and moved on with their heads averted, whilst only 2% stopped to 'chat' briefly. With regards to general interaction, including admissions assessments, ward meetings, group and individual psychotherapy, case presentations and discharge meetings, over the 129 days of combined hospitalisation at six institutions, pseudopatients had on average only 6.8 minutes of contact a day (Rosenhan, 1973, p. 256). For Rosenhan, this demonstrated a culture of depersonalisation and isolation faced by service users in mental health institutions.

Responses to Contact	Psychiatrists	Nurses & Attendants
Moves on, with head averted %	71	88
Makes eye contact %	23	10
Pauses, and chats %	2	2
Stops and talks %	4	0
Total number of attempted interactions	185	1283

Data adapted from Rosenhan 1973 'Being Sane in Insane Places', p. 255.

It could be argued that staff at mental healthcare institutions are simply busy or overworked, and do not have time for such questions from those that they care for. However, there are two problems with such a thought. Firstly, a similar experiment took place at Stanford University, in which a young person approached individual members of faculty who "seemed to be walking purposefully" and asked them one of six polite questions (Rosenhan, 1973, p. 255). In this investigation, it was found that 100% of the 14 faculty staff approached stopped and talked to the young person in order to fully answer their question, no matter how busy they seemed when they were interrupted (ibid, p. 255). Of course, the number of staff approached by the pseudopatients was much greater than the faculty staff that were approached, and it could also be argued that staff in a psychiatric institution may be aware that exchanges with service users could become 'challenging', despite the pseudopatients acting completely normally once in the institutions. Whilst an exchange with someone who looks like a student at a large and respected university is likely to be pleasant. I do not accept this argument, however. If one group of people in power (university faculty staff) are able to make time for those that they have a duty to (to educate), why is it acceptable for clinicians, who are in a position of power, to simply ignore reasonable questions from those that they have a duty of care to? We would not see it as acceptable for an oncologist to simply ignore questions and queries from all service users who had skin cancer, whilst making time for their patients who had lung cancer. Neither would it be acceptable for a teacher to make time for questions from all of their female students, whilst ignoring all males in the class. Therefore, I do not think it is acceptable to excuse the lack of interaction from clinicians with mental health service users in these institutions.

Notes from Rosenhan's pseudopatients mentioned feelings of invisibility and depersonalisation, not only because of the ignorance of staff towards them but also because of the actions of staff when the pseudopatients and other service users were present. In Rosenhan's own experience as a pseudopatient, he claims he witnessed other service users being beaten by staff whilst in the presence of several other service users. Similarly, staff were noted as often shouting abusive and derogatory language at service users when issuing orders, such as to get out of bed. However, it was also noted that this behaviour

quickly stopped when another member of staff entered the room or could be heard approaching. This implies that service users were not viewed with the same level of humanity as staff, and that abusive behaviour could occur in front of them as they were unreliable witnesses, simply because of their mental disorder diagnosis. Other notes from pseudopatients recorded instances of staff talking about service users as if they were not in the room, staff walking through treatment and assessment rooms as if a patient was not present, as well as a lack of notice or care regarding service users' medication, which all, bar two tablets of 2100 prescribed to the pseudopatients, were able to be disposed of without the notice of staff (Rosenhan, 1973, p. 256).

Rosenhan's experiment took place in the early 1970s, effectively demonstrating the flaws in mental healthcare that Szasz was writing about a decade before, both advocating for an end to negative psychiatric practices and for a new way of understanding mental disorders. However, in the past six decades, there have of course been significant changes in mental healthcare which may lead us to assume that the ideas of Szasz and examples from Rosenhan are no longer relevant. However, I argue that there are still significant failings in mental healthcare today, many of which are related to the issues Szasz wrote about. Therefore, his ideas about re-framing mental disorders in a way which would improve patient care are still very relevant today.

One of the major changes we can see from the time of Szasz and Rosenhan to the present day is the deinstitutionalisation of mental health services. Specifically, in the UK, the past five decades have seen large-scale, government-directed deinstitutionalisation of mental healthcare. This entailed the closure of mental health-specific 'psychiatric hospitals' and a shift to community-based care for mental health service users. This community-based care consists of day hospitals, outpatient hospital visits, community mental health teams, social care teams, short-term community residential care (such as support living accommodation, therapeutic communities or hostels) as well as some inpatient care, based in general hospitals, for service users with severe mental health conditions (Mind UK, 2017b, pp. 18-19). Community-based mental healthcare aims to engage mental health service users in treatments which, as closely as possible, reflect their normal life in the communities, the places in which they ideally will continue to thrive during and after their care (Bennet & Morris, 1983). Because of this, inpatient treatment that segregates service users from their communities should be avoided when possible. Although there were challenges with the initial transition from institution to community care for some service users, including a rise in homelessness amongst service users previously residing in institutions, in the long-term, studies have suggested that community-based mental healthcare has had several positive effects (Killapsy, 2006). For example, it has allowed service users to increase their "social

networks" and develop "independent living skills", whilst also showing levels of "improved quality of life", improved service user satisfaction, as well as a reduction in the need for re-admission (ibid, p, 249).

However, despite such drastic changes in mental healthcare the over the past five decades, service users have also been facing inadequate care far more recently. In 2008, the BBC produced a documentary which followed an experiment inspired by Rosenhan's pseudopatient study. The 'How Mad Are You?' experiment used 10 volunteers, five females and five males, five of which had a diagnosis of a psychiatric disorder and five who did not (Progler, 2009). Three mental health professionals, a psychiatrist, a psychiatric nurse, and a professor of clinical psychology, observed the 10 volunteers interacting with each other for one week and then attempted to identify those with psychiatric diagnoses. Unlike in Rosenhan's study, the experts in this experiment were asked to diagnose by observation alone and were not able to interview the volunteers. However, we must bear in mind that in Rosenhan's study, apart from their claims of auditory hallucinations, the pseudopatients answered all interview questions about their life truthfully. Therefore, other than understanding a volunteer's perception of themselves, it may have made little difference to clinicians' conclusions. During the week of observation, the volunteers took part in several tasks, such as orienteering, stand-up comedy, a simulation of being on a train, paintballing, card sorting and cleaning, all of which were designed to display key symptoms of mental disorder diagnostic criteria as contained within the DSM.

During the experiment, the clinicians were able to correctly diagnose two of the 10 volunteers. However, they also misdiagnosed one volunteer who had been diagnosed with a different mental health condition, and incorrectly believed that two volunteers without any history of mental health diagnoses were mental health service users.

Before their observations of the volunteers began, the clinicians discussed that they felt as if they had "insufficient time" to make proper diagnoses but were happy to participate in the study (Progler, 2009, p. 331). There have also been claims that this study 'unfairly burdened' the clinicians to diagnose with "insufficient information", as they were not able to interview the volunteers and were only able to observe their behaviours for a week (ibid, p. 333).

The Australian network SBS recreated the BBC's 'How Mad Are You?' 2008 study, as inspired by Rosenhan a decade later, in 2018. Once again 10 volunteers, five of which had "been diagnosed as mentally ill" and five who had not, took part in various tasks over a week (How Mad Are You?, 2018). The tasks were designed to highlight key symptoms of common mental disorders (Clinical Depression, Social Anxiety Disorder, Bipolar, Anorexia Nervosa, OCD and Schizophrenia) in volunteers whilst being observed by three psychiatric experts.

The three experts were the director of the largest psychiatric research centre in Australia, a senior psychiatric nurse in an emergency hospital and a clinical psychologist at a mental health retreat centre. The aim of the clinicians was to "evaluate" which of the five volunteers had been diagnosed with these disorders, and which had no history of mental disorder (ibid).

As well as observing the volunteers' behaviours before, during and after the tasks, clinicians also got to see their responses to on-camera interviews throughout their week, having being asked questions at various points such as: 'How did you feel when you found out about this task?', 'How is the task going?', 'How are you feeling now?', 'How did you find the test?' and 'Why did you feel like that?'. In this way, the experts also got to get an understanding of how the volunteers were feeling, as well as how they were outwardly presenting.

In this version of the study, the experts could make multiple guesses during the week about their evaluations, meaning they made more than 10 evaluations in total. The experts were able to correctly diagnose one volunteer with anorexia, correctly evaluate one volunteer as having no history of mental disorders, evaluate two volunteers with no history of mental disorders as having anxiety and schizophrenia, misdiagnose three volunteers and miss a diagnosis of bipolar for another volunteer. Similarly to the BBC's 2008 study, the clinicians claimed that their task was "difficult" because they didn't know about the volunteers' "backgrounds, professions and support networks", as well as claiming they had "only a tiny amount of evidence" to base their evaluations on (How Mad Are You?, 2018). However, I find these excuses, in both cases, unconvincing for several reasons.

Firstly, the average length of a GP appointment in the UK is 9.2 minutes, and since COVID, almost 50% of these appointments in England take place over the phone (Irving, et al., 2019; NHS Digital, 2020). Although mental health conditions that are considered to be more 'severe', such as Bipolar and Schizophrenia, or conditions which require specialist medication, such as OCD and ADHD are diagnosed only by psychiatrists. In these short appointments, GPs are allowed to and do, diagnose common mental health conditions such as anxiety and depression (Mind UK, 2017a, p. 10). Psychiatrists also diagnose more complex conditions with limited time, with mental health/psychological assessments lasting only about 30 to 60 minutes depending on NHS Trust (Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust, 2022; National Health Service, 2022; North Bristol NHS Trust, 2022). If GPs are allowed to diagnose and medicate anxiety and depression in less than 10 minutes, and psychiatrists can diagnose even more complex conditions in phone appointments of 30 minutes, and we believe that these diagnoses are correct and acceptable, then one week's worth of specifically structured behavioural observation should have been plenty of time for the three clinicians to identify volunteers with mental disorder

diagnoses. Thinking back to earlier in this chapter and our discussion of objectivity and subjectivity, we saw that a diagnosis of a mental disorder could be seen as subjective because a clinician is asked to diagnose with insufficient evidence. These short appointments are another constraint that could lead a clinician to diagnose without reasonable evidence. Therefore, reinforcing the idea that mental disorder diagnoses can be seen as subjective.

I also believe it is important to consider the types of symptoms the DSM-V uses as diagnostic criteria for mental disorders. Many of the symptoms listed in the DSM are observable behaviours, such as 'temper outbursts, 'trembling or shaking, 'avoidance' of certain situations, 'irritability', 'sleep disturbances', 'appearing tearful', 'inability to sit still and 'childlike silliness', amongst many others (American Psychiatric Association, 2013, pp. 88, 119, 125, 156, 163, 172, 208, 222). All of these diagnostic criteria are symptoms which could be observed, especially in situations designed to 'bring out these symptoms in service users with particular mental disorder diagnoses, as was the case in the 'How Mad Are You?' 2008 and 2018 studies. Furthermore, in the 2018 study, the clinicians also got to see how the volunteers were inwardly feeling at various points throughout the week from on-camera interviews in order to supplement their observations of outward behaviours. Therefore, compared to clinicians who diagnose mental health service users routinely from just telephone conversations and cannot observe such key diagnostic criteria, it seems that the clinicians in the study had a significant advantage.

One moment relating to the diagnostic criteria of mental disorders in the 2018 version of the study was particularly poignant, with an expert noting the 'non-scientific' nature of mental disorder diagnoses. During an eye-tracking task, in which the volunteers had to look at pictures of themselves and the other volunteers in tight outfits, the finding of the eye-tracking tests completely contradicted the clinical observations of the experts, leaving one to ask: "Do we go with our clinical observations or the science?" (How Mad Are You?, 2018). The one volunteer whose eye tracking was significantly out of range compared to the healthy population's standard deviation was an individual who the clinicians thought of as having a good relationship with their body image and coming across as confident and comfortable during the task. Ultimately, the experts decided to rely on the 'science' of the eye tracking test and correctly identified the volunteer with a diagnosis of anorexia from this information. I believe that this shows once again just how unreliable psychiatric diagnoses are, even when made by experienced professionals and leaders in the field. Despite observing the volunteers closely and hearing their thoughts and feelings about the test, the experts were not able to pick up on the behavioural signs that the eye tracking software could, which to them, served as the only indication for their diagnosis. If this service user did not have

access to such cutting-edge scientific equipment, their diagnosis would most likely have been missed, and given that this eye tracking test is not generally used as a diagnostic test for anorexia, and neither is it at all referenced in the diagnostic criteria of the DSM-V, anorexia nervosa in someone like this volunteer could easily go undiagnosed.

It could be argued, however, as the clinicians continued to mention throughout the study, that this way of evaluating service users is nothing like their daily way of working, and they would commonly talk to service users much more and therefore we cannot use this study to comment on the reliability of diagnoses. However, I believe this comment only adds to the subjectivity of mental disorder diagnoses. Not only is a diagnosis based on the clinician's interpretation of the service user's behaviour in relation to the criteria of the DSM-V, but also the clinician's subjective interpretation of the service user's own subjective feelings about themselves and how they feel in their sociocultural context. Again, thinking back to the discussion of subjectivity earlier, a clinician's interpretation of a service user's symptoms will be subjective because they likely lack all of the information they need to make a non-judgement-based claim, as well as many of the diagnostic criteria sitting on an ever-changing sliding scale which alters whenever we meet more people or experience different environments. This sliding scale about the extent of symptoms such as 'sadness' and 'anger' is also why a service user's interpretation of their own symptoms is subjective, as they will compare their own reaction to those of the society around them.

I find the claim that a mental disorder diagnosis is either based on clinical observation <u>or</u> science, and not both, extremely worrying as it suggests that, unlike physical disorder diagnoses and treatment, mental disorders cannot be treated or diagnosed reliably and objectively. This claim alone, along with the missed and misdiagnoses that these studies produced, once again shows how subjective and unreliable diagnostic criteria of mental disorders continue to be decades on from Rosenhan's experiment.

The point of these experiments, unlike Rosenhan's, was not to criticise mental healthcare, or draw attention to its inadequacies, but to reduce stigma. The two contemporary studies had the same aim: to show that mental health service users are often indistinguishable from anyone else, something that the incorrect, missed and misdiagnoses from the study could be interpreted as demonstrating.

Compared to the mid-90s, when Szasz and Rosenhan were carrying out their work, the stigma surrounding mental and mental ill-health has decreased as more people are diagnosed with these disorders and their occurrence becomes more commonplace in our society (Henderson, et al., 2020). This is not to claim in any way that there is currently no stigma faced by mental health service users, just that it has improved in certain ways since

the time of Szasz's and Rosenhan's publications. Therefore, perhaps we should not be criticising psychiatry in the way that Rosenhan and Szasz do. Maybe we should not suggest that there are too many diagnoses that are incorrect and come with a stigma attached that is hard to get rid of. As if fewer people are diagnosed with mental disorders, it is likely to increase the stigma for those who are diagnosed. The more diagnoses of mental disorders that are made, the more people who live day-to-day with a mental disorder and the more aware of neurodiversity we become. This in turn is likely to reduce stigma as the diagnosis of a mental disorder becomes more commonplace. If we decreased diagnoses because of the risk of misdiagnosis or stigma, serve users who are diagnosed still with mental disorder may face more stigma as mental disorder become less common.

Furthermore, it could be argued that we don't want to ignore someone with a mental disorder because diagnosing them might be stigmatising, we would likely still want to diagnose them so they can get the help and support they want. For example, our society may have an obesity problem, but it is becoming more problematic to use phrases such as 'fat' or 'overweight' because they are considered rude and stigmatising. Yet we do not want to ignore the problem of obesity because at a certain stage it becomes detrimental to an individual's health. We, therefore, may see it as more beneficial to diagnose someone with a mental health disorder, or as obese, in order for them to get the help, if they choose to improve their physical health, rather than to ignore the issues in an attempt to avoid stigma.

However, I believe that the 2008 and 2018 studies raise far more issues than the reduction of stigma. Both studies demonstrate that there are inadequacies in mental healthcare and the diagnostic criteria used to identify mental disorders. The mistakes made by the clinicians in the studies demonstrates how subjective and unreliable mental health diagnoses can be, whilst the complaints of the clinicians about the lack of 'time' they had to diagnose highlights how the diagnostic process that thousands of service users a year experience is unfit for purpose.

Also in 2018, a decade after the BBC's original experiment, it still appears that mental healthcare requires drastic improvement. In the UK, a review of the Mental Health Act was carried out which found several failings in the mental healthcare service which required action. Findings included: a lack of advocacy for both voluntary and detained patients, a lack of access to second opinions or the ability to appeal against treatment, a disproportionally high number of people from ethnic minorities being detained under the Mental Health Act, and a lack of patient-centred care (UK Government, 2018). In the same year, the Parliamentary and Health Service Ombudsman in the UK declared that:

"Patients with mental health conditions are being badly let down by the NHS, causing them and their families needless suffering and distress." (Parliamentary and Health Service Ombudsman, 2018a)

Similarly to the Review of the Mental Act, the ombudsman's investigations found that service users treated in community mental healthcare settings were faced with a system which failed to diagnose and treat effectively, communicated poorly with service users, failed to provide sufficient care to high-risk service users to avoid death, contained inadequate risk assessments to protect service users from assault, treated service users with a lack of dignity and infringed their human rights (Parliamentary and Health Service Ombudsman, 2018b).

Although it could be argued that these various 'problems' in our mental healthcare system, despite still being unacceptable, are still much improved from the problems it suffered from at the time of Rosenhan and Szasz, it is clear that there are still groups of service users disproportionately being treated and detained as well as service users having their autonomy removed and being at risk of abuse. Not only is service user care lacking, but the modern 'How Mad Are You?' investigations have shown similar sentiments to those which Rosenhan highlighted in 1973 with regards to the reliability of psychiatric diagnosis. With uncertain diagnoses, which could lead to service users unnecessarily facing stigma and experiencing drastically inadequate care, I believe, improvements must be made, and I suggest this is done by re-framing our views of mental disorders, as suggested by Szasz.

It is the various negative experiences of mental health service users, the questionable practices of psychiatric diagnosis and treatment, along with a lack of a definitive solution to the Dualism vs Medical Model debate in psychiatry that led researchers such as Szasz and Rosenhan to carry out their work which was seen by many as criticising psychiatric practice as well as advocating for a new understanding of mental disorders. Szasz's work 'The Myth of Mental Illness', in which he advocated for a new understanding of mental disorders, will be the focus of the rest of this paper, including a novel defence of his case against the *'In/Of'* Distinction. I will argue that in a society that has still not been able to overcome all of the factors that inspired Szasz's work, his reasoning cannot be overlooked and a key argument used against his ideas is clearly mistaken, and therefore, Szasz's ideas, and specifically the arguments used to defend his ideas, could be of potentially great benefit to mental healthcare today.

Chapter 2: Szasz's Eliminativist view of Mental Disorders

2.1 Explaining Szasz's Eliminativism

Thomas Szasz's 'The Myth of Mental Illness' was written in response to failures in the mental healthcare system in the mid-90s, the same problems that were demonstrated in Rosenhan's 'Pseudopatient' study and that I have argued still exist to some extent today. In it, Szasz suggests a new way in which we could understand mental disorders that would potentially overcome some of the negative aspects of mental healthcare at the time of its publication. As we have discussed in Chapter One, there is no resolution to the mind-brain problem, and therefore no definitively 'correct' way to view and treat mental disorders, and despite improvements since the mid-90s, there are still significant problems in mental healthcare today. Because of this, I argue that Szasz's ideas from 'The Myth of Mental Illness' are still relevant today, and once they are defended, we can see how their implementation could positively impact service user care.

'The Myth of Mental Illness' was first published in 1960 and claims that modern psychiatry falls foul of an error in its understanding of mental disorders- namely its claim that mental disorders are disorders at all. Szasz claims that psychiatry is responsible for 'systematically misinterpreting unwanted behaviours' as mental illness diagnoses that "point to underlying neurological disease", which are then often treated with psychiatric drugs (Szasz, 2011, p. 179). Szasz proposes that "mental patients", or 'mental health service users', should not be seen as "passive victims" of "pathophysiological" ailments which they cannot control and instead as "active players" that face the dramas and challenges of everyday life (ibid, p.179).

Szasz is a naturalist in his view of 'disorders', meaning that our understanding of health and disease should focus on "objective natural categories" that are not value or interest-driven, namely a focus on "biological function and dysfunction" (Kingma, 2013, p. 364). This view of health and disease is in contrast to that of normativism, which sees our understanding of diseases and disorders as being influenced by our social and cultural values which shift and change over time. Although for a naturalist, our values could impact how we recognise diseases and disorders, as well as influence how we treat them, our values do not influence what should be considered a disorder, that is dictated by nature. Therefore, for a normativist, there is no concept of a "real" disorder that can exist without being influenced by our cultural

and social values (ibid, p.365). Being a naturalist, Szasz claims the opposite of this; that a 'real' disorder can exist independently of our value judgements.

Szasz's naturalist claim that disorders exist independently of social values and cultural norms leads him to claim that a disease or disorder requires a physical dysfunction, including any disorders we claim are in the mind. It is this understanding of the concept of disease and disorder that then leads Szasz to argue that mental illnesses cannot be classed as disorders. Following his claim that disorders require physical dysfunction, Szasz then points out that many mental disorders do not present with an accompanying physical lesion, leaving him to conclude that mental disorders cannot, therefore, be disorders (Szasz, 1960). It is important to note that Szasz does not state that mental illnesses do not exist, only that they do not exist as disorders, as we most commonly understand them.

Szasz' argument against mental disorder, as presented by Kingma (2013, p. 365)

P1: (Naturalist Premise): What constitutes disorder is a dysfunction or lesion at a structural, cellular, or molecular level.

P2: (Empirical Premise): 'Mental disorders' are present without a physical lesion

C: Mental 'disorders' do not exist.

Szasz explains instead that the terms 'mental illness' and 'mental disorder' are errors in our understanding of people's psychiatry, and people that we may usually think of as having such illnesses or disorders have what Szasz refers to instead as "problems in living" (Szasz, 1972, p. xi). These 'problems in living', which we refer to as mental disorders, can therefore be influenced by our social values and cultural norms because they are not true 'disorders'.

For Szasz, a disorder must be caused by a physical dysfunction and occur independently of social values and cultural norms. Szasz is not claiming that mental ill-health does not exist, only that mental 'disorders' cannot exist as true '*disorders'* because they often occur without a physical dysfunction and are influenced greatly by sociocultural context. Therefore, what we refer to as 'mental disorders' are actually 'problems in living' which are influenced by our sociocultural context and often occur without any physical dysfunction.

Szasz acknowledges, even in his 1960s paper, that many people think that eventually all of the conditions which we call 'mental illnesses' may be able to be explained by a "neurological defect", no matter how subtle (Szasz, 1960, p. 113). This view, Szasz believes, would leave us with the inability to say that 'problems in the living' (currently referred to as mental disorders) are caused by troubles related to "personal needs, opinions, social

aspirations, values, and so on", as these are influences from our sociocultural context, not physical defects (ibid, p. 113).

If we view mental illnesses in this way, as being reducible to a neurological defect, they are then quite comparable to physical illnesses. In the case of mental illness, a defect affects the brain and manifests as mental symptoms. In the case of physical illness, a defect affects other parts of the body, for example, organs, tissues or bones, and manifests as symptoms related to the part of the body that is defective. This is not to say that a mental illness could not, through its mental symptoms, also affect people physically. For example, anorexia nervosa may manifest mentally as fear of gaining weight which, in turn, will affect a person physically by significant weight loss, tiredness, weakness etc.

Although some psychiatrists argue that today that "a number of neurobiological abnormalities have now been discovered for most, if not all, conditions we call mental disorders", there is certainly not a practical application of this claim in psychiatric practice (Aftab, 2017, p. 10). For example, the NHS explains that "there are no physical tests for depression" and tests such as blood tests or urine samples will be used to rule out physical disorders like an underactive thyroid which has similar symptoms to depression (National Health Service, 2019a, Online). Furthermore, it is important to recall that the Diagnostic and Statistics Manual (DSM), for all apart from a handful of disorders which are classified as "Neurocognitive Disorders" or "Medication-Induced Disorders" such as Alzheimer's or cannabis intoxication, specifies diagnostic criteria as symptoms, rather than of any observable, objective, physical defect (American Psychiatric Association, 2013, pp. xxx-xxxiv).

The assumption that mental disorders are no different to physical disorders in so far as they are caused by physical defects, as purported by the strong interpretation of the Medical Model, Szasz believes is flawed in two ways. Firstly, a person's belief, even one which we perceive as being 'incorrect', cannot be said to be as a result of a defect in a person's physical body. Just as we would not say that someone's belief in a religion or a political ideology is a result of a physical defect, Szasz (1960) argues that we should not say that someone's belief that they are someone or something they are not, that they are in constant danger, for example, is a result of a physical defect either.

Secondly, Szasz explains that drawing a "dualism" between mental and physical symptoms is incorrect (ibid, p. 114). This is because that when we talk about physical illnesses, we discuss their signs and symptoms, such as a raised temperature, a low iron count, or pain in a particular part of the body. In contrast, Szasz states that when we discuss symptoms of mental illness, we are not truly talking about observable signs and symptoms, but rather a

service user's understanding and "communications about himself, others, and the world about him" (ibid, p. 114). For example, if someone has a fever because of a physical illness, we can measure their temperature to prove that this is true. But if someone claims that they are 'feeling anxious, there are no tests we can do to prove this. We can observe the person's behaviour and compare it to other people's behaviours that we believe are 'normal' to see if there is a difference that suggests anxiety. However, thinking back to our discussion of objectivity and subjectivity in Chapter One, this judgement would lie on a sliding scale that is altered depending on our past experience and sociocultural context, making the judgement about someone's anxiety subjective, compared to an objective claim about someone's fever detected through taking their temperature.

To further exemplify this, we could use the example of someone who believes that they are in constant danger. This would only be seen as a sign or symptom of a mental illness if the observer believes otherwise, that the individual is not in danger. If the individual was being chased by a bear, the observer would probably conclude that the individual's feeling that they were in danger was warranted. In this way, it could be argued that mental 'disorders' or 'problems in living' are demonstrated by an illogical reaction to a person's situation, and, as mental disorders are diagnosed by a third party, the service user's reaction may be 'illogical' or 'irrational' in the eyes of the clinician.

However, there is a possibility that some might claim that logic is a universal, and therefore would we not want to see someone who cannot reason logically as having more than just a 'problem with living', and claim that they really do have a disorder that doesn't allow them to reason logically? For example, if someone could not follow Modus ponens (e.g., not agreeing with the following logic- P1: I go to work every Wednesday. P2: Today is Wednesday. C: Therefore, I will go to work.), would we not want to say that there is more affecting them than simply their sociocultural context? Although we do not have time to explore this viewpoint regarding the universality of logic thoroughly as a possibility, I point to a study by Nisbett to initially dismiss this idea. In his book 'The Geography of Thought', Nisbett (2004) exemplifies how people in Western societies and people in Asian societies reason differently, with those from the West adopting a more 'individualistic' thought process, and those from Asia adopting more 'holistic' reasoning. This could be seen to demonstrate that 'logical reasoning' isn't necessarily a universal, it appears that our cultural background affects our reasoning. However, the claim that logic is universal being used to counter Szasz's view of mental disorders, and if a lack of reasoning skills is a mental disorder, is certainly one that merits more discussion than I have to ability to cover in this paper.

For Szasz, and for myself, as will become clear throughout this paper, a judgement about a symptom of a mental illness is reliant on a value judgement. The beliefs or actions of a service user must not align with the "ideas, concepts and beliefs" of a practitioner and their society for a practitioner to consider them as having a mental disorder (Szasz, 1960, p. 114). To say that someone has a symptom of a mental disorder, the very same things used to diagnose mental disorders, is to therefore make a judgment based on the 'sliding scale' we have previously discussed which is affected by social and ethical context, rather than an "anatomical and genetic context" as is used when looking at physical symptoms (ibid, p. 114).

The acknowledgement that the symptoms, and therefore the diagnosis, of a mental illness, are inherently linked to value judgements which are influenced by social and cultural context is one which I do not believe opponents of Szasz have taken into consideration. Because of this, I propose that not only is Szasz's view of mental illness not disproven, whilst also being relevant today, but also that acknowledging this social and cultural influence on the diagnosis of mental illness could lead to improved outcomes for service users and the practitioners they see. These are ideas that will be explored in chapter four of this paper.

Szasz not only disagrees with the medicalisation of 'problems in living' because of how they are diagnosed, but because he believes that their medicalisation shifts the power and responsibility for behaviours from the service user "to physicians, specifically to psychiatrists" (Benning, 2016, p. 293). Writing in 2011, reflecting on 'The Myth of Mental Illness', Szasz maintains that there are errors in our treatment of mental health service users today, especially those with more 'serious' conditions. Szasz highlights the disparity between patient care for those with a physical illness and those with a 'mental disorder', with psychiatry viewing their service users as "sick patients needing psychiatric treatment, regardless of whether they seek or reject such help", whereas those with physical illnesses have the right to refuse or withdraw treatment at any time during their care (Szasz, 2011, p. 182). This demonstrates how, in the case of physical medicine as a service, the service user and their autonomy are "supremely important", as they are "free to seek, accept or reject medical diagnosis and treatment" (Szasz, 2011, p. 181). In contrast, psychiatric treatment does not put the service user and their autonomy first. Instead, psychiatric treatment starts with the assumption that a service user may be a danger to themselves or others, so the medical professional's "moral duty" is to protect the service user from themselves and to protect society from the service user (ibid, p. 181). Therefore, just as is the case with physical health service users, Szasz advocates that there should be a communicative relationship between a psychiatrist and a service user. Rather than what Szasz views as the

current imbalanced relationship, with the service user being coerced or controlled into having particular treatments that are mandated or supported by the state.

A key example of this can be seen in the right for a person to end their own life. Writing about schizophrenia, Bleuler (1911) stated that one of the main symptoms of schizophrenia is suicidal thoughts and intentions. However, no matter how much a mental health service user wants to end their life, the psychiatrist is bound by law to stop them. Bleuler and Szasz view this as "entirely inappropriate cruelty" from the psychiatrist, as they are 'forcing' the service user to continue a life which the individual themselves has deemed to be 'unbearable' (Bleuler, 1911, p. 488). After being stopped from committing suicide, Bleuler points out that it is highly likely that the life which the service user is forced to continue will be full of "humiliating surveillance" and "restraint", in an attempt to stop further suicide attempts (ibid, p. 488). The service user, for Bleuler and Szasz, would not have to go through such suffering if they had patient autonomy and were respected by psychiatric practitioners, rather than having to be coerced, restrained and kept in hospitals just because of government mandates. It could be argued that by taking what could be seen as 'cruel' actions by the psychiatrist, the lives of people with schizophrenia are being saved through such restraint and surveillance and they will not be suffering when they make a recovery. However, Bleuler argues that "only in exceptional cases" would service users that he has cared for actually go through with their suicidal thoughts, even if they were allowed to (ibid, p. 489). He also asks the question: Even if more service users with schizophrenia did die by suicide, does this justify "the torture [of] hundreds of patients" who are kept in psychiatric hospitals (ibid, p. 489)? It could be argued here that assisted suicide of service users with physical health disorders is not legal, and therefore mental health service users who wish to commit suicide are just being subjected to the same rules as physical health service users. However, withdrawal of life prolonging treatment is legal for physical health service users, a right which mental health service users who are deemed to 'lack capacity' do not have.

Bleuler wrote this paper in 1911, with Szasz originating his work in 1960, therefore it may seem surprising that even 50 years after he originally wrote 'The Myth of Mental Illness', Szasz still refers to Bleuler's work and believes that there is 'state-mandated control' of some mental health service users (Szasz, 2011). Szasz explains that mental healthcare in the USA today is different to when he began writing in 1960, with there previously being very little responsibility from the government for the healthcare of the public (Szasz, 2011, p. 179). At the time of Szasz's first publication of 'The Myth of Mental Illness', any mental health service users with more serious mental health conditions were considered 'incurable' and sent to state mental hospitals, whilst voluntary patients, and patients from more affluent families paid "non-psychiatric physicians" for private treatment (ibid, p. 179). More recently in

the USA particularly, however, Szasz explains that there is very little distinction between private and state patients in mental healthcare, with the care of almost all mental health service users being the responsibility of the government and their treatment being funded by public money (ibid, p. 179). In the UK, the Government funded National Health Service provides the vast majority of care for UK residents, for both physical and mental health service users. In both cases, the majority of mental health service users who are detained under the mental health act and treated in hospitals are under the care of government-controlled institutions and have been detained under laws set by the same government. For Szasz, this government-mandated care of mental health service users, in order to prevent them from being a danger to themselves or others, not only demonstrates the medicalisation of mental healthcare today, as mental health service users are often treated medically in hospitals that also cater for physical health service users but also its politicisation, how governmental control greatly impacts a mental health service user's care. Therefore, Szasz claims that today there is legally no "non-medical approach to mental illness", just as there is no government approved non-medical approach to the treatment of cancer or heart disease, as once a person receives a diagnosis, they then legally must be treated in the ways that the government has deemed appropriate, and unlike physical health service users, those with what could be considered more serious mental disorders cannot refuse treatment and would be instead detained (ibid, p. 179).

However, even if mental disorders are being medicalised, we may ask: 'what's the problem with that in today's society?'. We have discussed why the medicalisation of mental disorders was a problem for Szasz in the 1960's, but it could be argued that today, even if mental health service users are placed under the care of government run organisations, there is little problem as their treatment is far better than that of service users in the 20th century. However, the continued medicalisation of mental disorders means that mental health service users are subjected to care which, as we discussed in chapter one, is faced with similar problems today as it was at the time of Szasz's original publication. Therefore, I argue that Szasz's concerns regarding the medicalisation of mental disorders still stands, and that his alternative understanding of such disorders as 'problems in living' could alleviate some of the care issues that service users face.

2.2 Why a Defence of Szasz's Eliminativism is Important Today

It is generally accepted that care for mental health service users in the early to mid- 20th century may not have been the most appropriate, with practices such as lobotomies, insulin-induced comas and electroconvulsive therapy being forced on service users, previously known as 'inmates' of 'lunatic asylums' (National Archives, 2022). Reflecting on his rejection

of the sentiment that all psychiatry helps service users, Szasz maintains that mental hospitals were:

'…like prisons not hospitals, that involuntary mental hospitalisation [was] a type of imprisonment not medical care, and that coercive psychiatrists function[ed] as judges and jailers not physicians and healers' (Szasz, 2011, p. 180).

Thankfully, this cannot generally be said about the treatment of mental health service users today, following a shift from institutionalisation to community care. However, in the previous chapter we discussed extensively how, although these improvements have been made since the time of Szasz's writing, there are still major failings in the treatment of mental health service users. Just as Szasz and Rosenhan argued at their respective times of writing, the care mental health service users are receiving today is: unreliable- in terms of uncertain diagnoses, dehumanising- in terms of lacking access to second opinions, lacking advocacy and being detained, unfit for purpose- with service users facing abuse and lacking sufficient care which leads to death, as well as discriminatory- with certain groups of society more likely that others to be detained against their will under the mental health act, as well as mental health service users experiencing stigma (UK Government, 2018).

Because of the issues with mental healthcare Szasz saw in the 1950s and 60s, he saw that there was a need to re-frame our understanding of mental 'disorders' so that care improved for mental health service users. As previously discussed, Szasz claimed that mental 'disorders' cannot be true disorders, as there cannot be an objective and value-free definition of one, as there can be with physical illnesses. Therefore, instead of medicalising mental disorders in the way that we do physical disorders, we should better understand the symptoms that service users face as 'problems with living', taking into account the extent that an individual's experience can impact mental health, as well as how diagnoses of mental disorders are subjective as they are made on a 'sliding scale' based on a clinician's own sociocultural context and their often limited understanding of a service user's context. I argue that issues similar to the ones that inspired Szasz to write 'The Myth of Mental Illness' still impact mental healthcare today, and therefore we should not dismiss the suggestions Szasz made which, if taken further, could improve care for mental health service users.

In 'The Myth of Mental Illness', Szasz is not suggesting new treatments for mental illnesses, but instead promoting that we take a fresh look at the things we currently call 'mental illnesses' in the hopes that its practical implications would improve care. Looking at these conditions through the lens Szasz has created leads us to question whether mental illnesses really are illnesses or, as Szasz suggests, 'the expressions' of someone struggling with the challenges of day-to-day life: 'problems in living' (Szasz, 1960, p. 117). A concern with this

re-framed and re-named view is that it could promote a lack of help for people struggling with 'problems in living', as it criticises the use of medication and also can be seen as diminishing the struggles people face as simply challenges that everyone must go through. Szasz maintains however that his book is not a 'contribution to psychiatry', stating whether or not people should receive treatment, but a commentary 'about psychiatry', investigating how psychiatrists and service users interact (Szasz, 2011, p. 181). In his later work 'The Ethics of Psychoanalysis' (1974), Szasz thoroughly discusses his thoughts surrounding how service users with so-called mental illnesses should be treated by psychiatrists. Szasz understands that, most commonly, psychoanalysis is the exertion of influence from one person on another, the psychotherapist and the service user. Although given the label of 'psychoanalysis' because of the context of the two people involved in this particular exchange, Szasz sees this treatment as part of a larger type of social interaction in which influence is exerted over people- advertising, education and religion for example. Often, Szasz states, this influence relates to values and trying to persuade someone to adhere to your values. The values that a psychotherapist has are likely to align with the widely accepted norms of their society, whilst the person they are providing 'therapy' to will most likely have values which do not seem to fit with the society they find themselves in, hence them seeking therapy. It is not only 'values' which are shared, and possibly 'converted' during psychotherapy, Szasz claims that there are psychotherapists who aim to 'treat' their patients by 'converting' their conduct (Szasz, 1974). For example, a psychotherapist, and the society they are surrounded by, may value happy marriages. When a couple finds themselves diverging from this accepted norm, they may seek therapy. During this therapy, a psychotherapist may seek to convert this unhappy couple into a happy one and convert their conduct into ways that are accepted by society. The same can be seen for therapists who aim to 'treat' criminals to convert them to non-criminals, or those therapists who practice conversion therapy for homosexuals (Szasz, 1974, p. vi). For Szasz however, he does not believe that these practices should be called psychoanalysis, even though their aims and methods may be described as such. This is because Szasz believes that the examples of psychoanalysis noted above "curtail autonomy", the opposite aim of what psychoanalysis was developed by Freud to do (ibid, p. vi). Instead, Szasz thinks that the term 'psychoanalysis' should be characterised by its aim of increasing a service user's knowledge about themselves and others, building their understanding of freedom of choice and personal conduct and constructing a contractual, rather than 'therapeutic' relationship between the service user and psychiatric professional (ibid, pp. vi-v). Szasz suggests a name for this 'revised' type of psychoanalysis: 'autonomous psychotherapy' (ibid, p. 6). This name diminishes connotations of one-sided power held over the service user to convert their behaviour. Instead, 'autonomous psychotherapy' puts the aim of Szasz's theory first- to

'preserve' and 'expand' a service user's autonomy through a contractual relationship and agreed aims between the service user and professional (ibid, p. 7).

Similarly to Szasz, in chapter four of this paper, I will explain further how much of an impact our context and values influence our views of mental disorders and service users we believe to have these conditions. I will also comment on how this 'new' framing of mental disorders could positively impact psychiatric practice and support the sort of 'overhaul' of current psychiatric practice, just as Szasz proposes in 'The Ethics of Psychoanalysis'.

So far, we have outlined Szasz's suggestions for a new understanding of mental disorders which he wrote a response to significant failures in mental healthcare in the mid-90s. I have also argued that similar problems to those which effected mental healthcare at the time of Szasz's publication are still present today and that therefore we should not dismiss Szasz's ideas which could potentially help us to improve the care of service users. Before we can accept Szasz's view of mental health, however, we need to address the challenges it has faced from its critics, challenges which for many have been the undoing of Szasz's 'Myth of Mental Illness'. I disagree, however. The two main challenges that Szasz's view faces are what I will call 'The Argument from Biology' and 'The Argument from the *'In/Of'* Distinction'. I argue that these challenges are not enough to dismiss Szasz's ideas about mental health, with The Argument from Biology simply not having enough scientific evidence to date, and the Argument from the *'In/Of'* Distinction actually aiding Szasz's claim about the subjective nature of what we call mental disorders, in such a way that our judgements about them are made by placing a service user's symptoms somewhere on a sliding scale that is altered by our experiences and background. In the next chapter of this paper, I will discuss the *'In/Of'* Distinction in depth, explaining not only how it fails to disprove Szasz's claims but also how it supports Szasz's views surrounding the impact that an individual's context had on their experiences because of how subjective mental health is.

I will also suggest in my final chapter of this paper, that if we were to re-frame our views of mental illness in a way such as Szasz has, to take into consideration the subjective value-judgments that affect our understanding of mental health to potentially de-medicalise it, that our new understanding of mental illness could help address the concerns of the 2018 review of the Mental Health Act.

2.3 The Argument from Biology Against Szasz

Szasz claims that mental disorders exist without physical lesions. Therefore, if it was proven that all mental disorders were caused by neurological dysfunction, Szasz's claim could be said to be false. Some conditions in the DSM-V already rely on the detection of physical dysfunction to be diagnosed, such as Alzheimer's, Huntington's and Parkinson's. The mental

disorders stemming from these conditions are classed as 'Neurocognitive Disorders' and have diagnostic criteria which include a previous diagnosis of a psychical condition which is often identified by physical diagnostic markers such as the identification of certain types of genes (American Psychiatric Association, 2013, pp. 603-604). In previous editions of the DSM, these disorders were called 'organic' brain disorders, again being separated from other mental disorders whose causes were unknown (e.g., American Psychiatric Association, 1968; 1980). If some disorders in the DSM have been found to have their aetiology in physical neurological disorders, as research progresses it may be reasonable to infer that, in future editions of the DSM, more mental disorders may have biological diagnostic criteria, suggesting that all mental illnesses could possibly stem from neurological dysfunction. At first, this view would seem to disprove Szasz's argument, one of the premises of which is that 'mental disorders occur without a physical lesion'. However, Szasz claims that if it was proven that all mental disorders were caused by neurological dysfunction, this would actually verify his argument (Szasz, 2011).

A person could be initially diagnosed with a mental disorder, such as obsessive-compulsive disorder, but through further investigation, they could then be found to have PANS, an autoimmune neuropsychiatric disorder caused by a strep infection (National Institute of Mental Health, 2019). The strep bacteria mimic the body's own bacteria so when the immune system finally detects the step, it also attacks its own bacteria which can lead to neuropsychiatric symptoms such as OCD-like traits, tics and anxiety (ibid). This person would have been misdiagnosed initially, as they never had OCD, they had an undetected biological disorder which mimicked the symptoms of OCD.

Similarly, Abbott (2019), when writing about Susannah Cahalan's (2019) research surrounding Rosenhan's experiment, notes that her paranoia, hallucinations and seizures, which were initially treated with antipsychotics, were eventually diagnosed as symptoms of autoimmune encephalitis, a physical, rather than mental disorder. Although it may be claimed that Cahalan's recovery was thanks to "front-line medical science in the context of psychiatry", just as Szasz does, I believe that psychiatry did not aid in her recovery, but instead wrongly medicated her for 10 years until a clinician specialising in physical medicine was able to correctly diagnose her (Abbott, 2019, p. 623). For Szasz, these errors do not suggest that mental disorders can appear with physical lesions, but instead that disorders which are initially diagnosed as mental illnesses but are then found to have a biological cause, were misdiagnosed. These misdiagnosed mental disorders then need to be re-identified as physically-based disorders, whilst those with no physical basis can be re-classified as 'problems in living'.

Of course, healthcare research could theoretically reach a stage where all of the conditions we consider 'mental disorders' are found to stem from a physical neurological defect. This would then mean that there are no 'problems in living' as Szasz claims there are. However, although this may leave Szasz's ideas about 'problems in living' redundant, it would prove his claim that disorders can only exist with a physical defect and is likely to address the problems that Szasz tries to tackle. Szasz re-classifies mental disorders as 'problems in living' as they lack the objective diagnostic criteria that are used for the diagnosis of physical disorders. These physical disorder diagnoses are considered objective because the clinicians making them have enough evidence to claim as a matter of fact that a psychical defect is present or not. The diagnoses of mental disorders, however, can be considered subjective, because clinicians and service users need to make judgement calls about the extent of symptoms. These judgements will be based on how this particular experience relates to the experiences of interacting with others, as well as clinicians often having little time to gather enough evidence to make a claim of a diagnosis. The unreliability of mental disorder diagnoses means that people can be misdiagnosed and then unnecessarily be faced with substandard treatment. However, if all mental disorders could be diagnosed objectively by their physical neurological defect, then it is likely that there would be far fewer misdiagnoses and that there would be clear physical treatment guidelines to support these service users. Therefore, we would not need to re-frame mental disorders as 'problems in living' as they would be classed as neurological disorders with physical bases and appropriate diagnostic criteria.

Similarly to Szasz's view of disease, Andreasen claims that mental disorders are caused by brain dysfunction. However, rather than then claiming that mental disorders cannot be true disorders because they occur without dysfunctional brains, Andreasen sees mental disorders being re-classified as a 'subset' of brain disorders. Andreasen explains: "when cells in our brains go bad" we can experience problems with "attention and memory" or we could experience mental disorders, such as "schizophrenia and depression" (Andreasen, 2001, p. 7). Therefore, a mental disorder *is*, for Andreasen, a form of brain disorder, as it is caused by a malfunction of the brain in some way that leads to psychological symptoms. Think links to Szasz's claim that many conditions we view as mental illnesses, may have been misdiagnosed and be able to be explained eventually by dysfunction in the brain.

Graham claims, however, that this view from both Andreasen and Szasz is flawed, as it suggests that psychological or behavioural symptoms of brain damage or dysfunction would become "enough" evidence to diagnose a mental disorder, and therefore also implicate neural dysfunction (Graham, 2013, p. 517). This is not the case, argues Graham, as closed head injuries often lead to psychological symptoms such as impaired vision, agitation and

confusion, but they are not seen as mental disorders, instead these are classed as symptoms of a physical injury. Graham also states that Andreasen's view is incompatible with the understanding of mental disorders in the DSM, as mental disorder diagnoses are made from manifestations of symptoms alone, rather than any physical evidence of how these symptoms came about. There are some exceptions in the DSM-V, those classed as neurocognitive disorders as previously mentioned. For the most part, however, the DSM does not claim that mental disorders are caused by neurological dysfunction, and the diagnoses of these disorders are not reliant on any such physical evidence.

However, just because the DSM makes no claims about the cause of psychological symptoms for most mental disorders, it does not mean that they deny that mental illnesses could be caused by neurological dysfunction. It simply means that there is not enough evidence to assume this for all conditions that are currently considered mental disorders. Furthermore, Szasz maintains that there are conditions which we currently consider to be 'mental illnesses', that have little to do with biology because they rely on subjective judgments about the behaviour and the decision of another person to diagnose. For Szasz, the term 'mental illness' cannot become "devoid of meaning" by biological explanations being found for all conditions, because the term refers to more than just symptoms, but to the judgement of people by others (Szasz, 2011, p. 180).

When arguing against Andreasen, Graham also quotes the DSM-III, rather than the current DSM-V(TR). The DSM-III originally stated that diagnoses are based on the "clinical manifestation" of psychological 'disturbances', rather than "how the disturbances have come about" (American Psychiatric Association, 1980, p. 7). This 'explanation' of mental disorders is not only no longer used in the DSM-V but is actively contradicted. For example, diagnoses of conditions classed as 'Substance-Related Disorders' require medical professionals to specify what the 'use disorder', 'withdrawal' or 'intoxication' is related to or caused by, such as alcohol, cannabis or opioids (American Psychiatric Association, 2013, pp. xxiv-xxv). In this way, we can see that there is no claim from the DSM-V that medical professionals must not consider how symptoms have come about themselves. Therefore, as long as diagnostic procedures for each disorder were being properly followed, a medical professional could assume whatever they like about how symptoms come to occur, so long as that assumption is not used for diagnosis of conditions which do not specifically require a cause as diagnostic criteria.

Graham also contradicts himself when he states that Andreasen's view is incompatible with the DSM-V, as he has previously stated that her view of mental disorders would mean that symptoms alone would be enough to diagnose such disorders, which in the DSM-V they are.

For most disorders, the DSM-V relies on groups of symptoms alone to specify and diagnose a mental disorder, so just as Andreasen's view may imply, psychological symptoms are 'enough' to diagnose a mental disorder, as nothing stops this from implying that there is an underlying neurological dysfunction that causes this. Therefore, both Andreasen and Szasz's assumptions that mental disorders, or conditions that are misdiagnosed as mental disorders, are caused by physical dysfunctions of some sort in the brain, still stand.

2.4 The Argument from the *'In/Of'* Distinction Against Szasz

If we accept Szasz's and Andreasen's views that mental disorders, or conditions we refer to as mental disorders, are caused by some sort of physical lesions, then they can be considered as a subset, or a type, of neurological disorder. If this is the case, Graham (2013) claims that a neurological disorder would be considered a "diagnostic truth maker" for mental disorders (p. 515). This is because a mental disorder could not exist without a neurological lesion, which would also make it a neurological disorder. However, Graham disagrees with this view. For Graham, a mental disorder is 'based', or 'physically realised' in the brain, but this does not necessitate, as Szasz claims, that there is a malfunction of this brain. A person with a mental disorder, therefore, has an illness that is 'based' in the brain, but it does not mean that their brain is "damaged, diseased or disordered" (ibid, p. 515). In this way, Graham claims that mental disorders are based '*in'* the brain, but are not disorders '*of'* the brain itself- this, he coins, the "in/of distinction" (ibid, p.516).

At first, the view that 'the mental' can be separated from 'the physical' may seem as being in agreement with metaphysical dualism. This agreement is not acceptable for medical science, Graham claims because it is too theoretical (Graham, 2013, p. 515). However, Graham explains that the *'In/Of'* Distinction is not actually metaphysically dualistic in its view of the mind and brain because he draws a distinction between the "existential platform" something is 'in' and the place something is 'of' (ibid, p. 516). Therefore, for Graham, just because the brain is the 'house' of the mental disorder, whether it be biologically or chemically, it does not necessarily mean that the brain or the 'house' itself is disordered. Graham exemplifies this with five examples of the *'In/Of'* Distinction that we will explore in detail in the next chapter, as well as the flaws that can be found in them.

In this chapter, we have outlined Szasz's suggestions for a new understanding of mental disorders as seen in 'The Myth of Mental Illness'. I claim that these ideas are still relevant today because similar problems in mental healthcare to those which inspired Szasz to write his paper still impact mental healthcare today. We have discussed how Szasz's ideas overcome The Argument from Biology and, in the next chapter, will discuss in detail how they can also overcome the Argument from the *'In/Of'* Distinction.

Chapter 3: Hermeneutics and the *'In/Of'* Distinction

3.1- Exploring common *'In/Of'* distinction examples

3.2- Critique of the *'In/Of'* Distinction from hermeneutics

3.3- Responses to the criticism from hermeneutics

3.1 Exploring common *'In/Of'* Distinction examples

The Argument from the *'In/Of'* Distinction is the second of the two main arguments that I claim are commonly used to dismiss Szasz's theory to re-frame mental disorders as 'problems with living'- issues which are greatly influenced by sociocultural context and experiences. In this chapter, I will not only argue that the 'In/Of/ Distinction is not enough to dismiss Szasz's ideas, but that the distinction actually reinforces Szasz's idea that our understanding and our diagnoses of mental disorder are highly influenced by not only a service user's context and experiences but also the context and experiences of the diagnosing clinician. Once we have disproved this second argument against Szasz, we are then left to see how his ideas are not only relevant to our modern mental healthcare context, being inspired by similar problems that mental health service users face today, but that they are also defensible against arguments commonly used to dismiss them. Therefore, we are left with an opportunity to discuss how Szasz's ideas could positively impact mental healthcare today.

Graham (2013) exemplifies the *'In/Of'* Distinction, which can be used as a cornerstone in the criticism of Szasz, using five examples that take place in an eventful motel.

The first example from Graham surrounds a clock and an individual who travels to a motel in a different time zone. The individual has set a manual alarm clock for the time zone in which they usually reside, Georgia. The individual has then travelled with the alarm clock to a motel in a different time zone, Texas. When the individual looks at their clock in Texas, the wrong time is displayed on the clock or, as Graham explains, "the wrong time is registered *in* the clock" (Graham, 2013, p. 516). The clock is failing to show the correct time for Texas, but there is no physical error of the clock itself, it is still mechanically functioning perfectly fine; it is tracking seconds, minutes and hours accurately. For Graham, this lack of physical malfunction means there is not an error *'of'* the clock. An error *'of'* the clock could occur if, during the journey from Georgia to Texas, the clock's battery died, so that it was no longer accurately tracking seconds, minutes, and hours, and therefore was not showing the correct time for either Georgia or Texas. Similarly, if the mechanical workings of the clocks were damaged during the journey meaning they began to run much more slowly, the clock would still be 'running' but it would not be accurately tracking seconds, minutes and hours due to a

physical malfunction '*of*' the clock. In both of these examples, there is a clear physical problem which causes the clock's time display to be incorrect, these are examples of errors '*of*' the clock. In contrast, in Graham's example, the wrong information is being displayed to the user, meaning that there is an 'error', but it is not due to any physical malfunction of the clock which is still tracking seconds, minutes and hours accurately. This cannot be an error '*of*' the clock, due to there being no mechanical malfunction, but Graham labels this as an error '*in*' the clock as we understand that the clock's incorrect display is an error.

Graham's second example concerns a doorbell at the motel. For Graham, the function of a doorbell is to alert the person inside of the room that there is someone at the door. Normally, the doorbell fulfils this function, it "carries the information", in the form of a ring, that someone is at the door (ibid, p. 516). However, somehow at this motel, a squirrel has managed to press the doorbell which causes it to ring as if a person was at the door, and when the guest goes to the door, they will of course not find a person as expected. For Graham, in this case, the doorbell is "failing to do what it was designed or supposed to do", it is not fulfilling its function of notifying the guest that there is someone at the door (ibid, p. 516). In a similar way to the alarm clock, the wiring and electrics in the doorbell are functioning perfectly, so there is no error '*of*' the doorbell for Graham. However, there is an error '*in*' the doorbell as the wrong information is contained within the its ring. An error '*of*' the doorbell could be seen in a case where the mechanical workings of the doorbell mean that when a person pushes the button, no signal is transferred in order to produce a ring. Because there is a clear mechanical error in this example, Graham would label this as an error '*of*' the doorbell. However, once again in Graham's original example, the motel doorbell has no mechanical malfunction meaning there cannot be an error '*of*' the doorbell. But because it has been made to ring by a squirrel, it does not alert the guest to a person outside of their door, something that Graham claims that it was "designed or supposed to do" (ibid, p. 516). Therefore, there is an error related to the doorbell, but it is one '*in*' the doorbell, rather than '*of*' the doorbell.

Both examples so far have been scenarios in which an object has not functioned in the way that the user would expect, without there being a malfunction '*of*' the objects themselves. For Graham, an object doesn't necessarily have an error '*of*' itself in order to have an error '*in*' it, it is simply that without the physical substance of the object, there would be nothing to 'display' or 'present' the error '*in*'. Relating this back to his claim about brains and mental illness, for Graham, without the physical substance of the brain, there would be nothing for a mental disorder to appear '*in*', but as with the examples we have discussed so far, this does not necessitate that there is a physical error '*of*' the brain.

The next example from Graham is about a motel guest's laptop. The guest is using their laptop over the motel Wi-Fi to reserve a room in another motel at their next destination, San Diego. However, the software that is running on (or *'in'*, for Graham) the hardware of the guest's laptop has a malfunction when processing the word 'Diego', as it instead processes it as 'Francisco', making it difficult for the guest to book make their next reservation. Graham points out that there is no malfunction of the laptop's hardware here, just like the mechanics of the alarm clock and the wiring of the doorbell, it is functioning perfectly. An error *'of'* the laptop would require its hardware to be malfunctioning. For example, if the guest spilled a drink on his laptop which caused several keys on the keyboard to become unresponsive, we could see there as being a physical error *'of'* the laptop, specifically *'of'* the keyboard. However, there is no physical malfunction '*of'* the laptop in Graham's example, it is the software that is running *'in'* or on the hardware contains which contains a glitch, which causes the 'error' of 'Diego' to be processed as 'Francisco'. There is not an error *'of´* the laptop, which is functioning fine, but an error *'in'* the laptop, due to the software it is running.

The penultimate example from Graham takes us away from the guest's motel room to its reception area where the guest finds a pregnant woman complaining of morning sickness. Sickness and nausea are both bodily conditions, however, Graham explains that because the woman is pregnant, we do not see her symptoms of morning sickness as an indicator of a "biologically unhealthy" or otherwise malfunctioning body (ibid, p. 516). Morning sickness is a normal part of pregnancy and Graham explains that in most cases, where it is not extreme, it can be an indicator of normal and "healthy" adaptive bodily function to protect a foetus from some foods (ibid, p. 517). Rather than the mechanics, electronics, or hardware functioning perfectly in this example, we can see that (so long as we interpret morning sickness as a 'normal' and 'healthy' part of pregnancy) the woman's body is not suffering any kind of biological malfunction. However, she is still experiencing physical symptoms of sickness and nausea. If a woman in the motel lobby was experiencing sickness and nausea but was not pregnant, we would likely think that she needs some form of medical help in order to relieve these symptoms which we often assume are the result of an illness, a malfunction (or error) *'of'* the body. However, because this lady is experiencing morning sickness, a normal part of pregnancy that does not represent a biological malfunction, for Graham, this exemplifies how symptoms are manifesting *'in'* the body without there being an error *'of'* the woman's body itself.

Graham's final example takes us out of the motel to a lake where the husband of the pregnant woman is rowing. The man stops for a break and places his oar straight down in the water and to his surprise, as he has never been rowing before, the oar appears bent. The man has never been taught about refraction and the optical illusions it can create, as

our visual system does not automatically correct the effects of refraction. This illusion provides the man with misinformation about his oar, despite his visual system functionally perfectly. In a scenario where a man is rowing but struggles to judge if his oars are adequately in the water due to a depth-perception problem with his eyesight that is not corrected by glasses, we would say that there is an error *'of'* the man's visual system; there is a biological malfunction or error with his visual system which causes him to be unable to perceive depth properly. In contrast, Graham explains that in his example we would not see there as being an error *'of'* the man's visual system, because it is again functioning biologically perfectly. Rather we should see that there is a "failure to furnish" the man with the correct understanding of refraction, which instead demonstrates an error has occurred *'in'* the visual system (Graham, 2013, p. 517).

These five examples are used to demonstrate that there can be an error 'in' something, like the clock, the laptop, the doorbell, the body or the visual system, without there being an error 'of' these things, which are working without any physical dysfunction. In this way, Graham aims to disprove Szasz's claim that true *disorders* must have a physical base, meaning that mental *disorders* must be linked to a neurological defect. For Graham, these scenarios exemplify how there could be a mental disorder that is 'based' or 'physically realised' in the brain, without there being a biological malfunction of the brain itself, like how there was no mechanical malfunction of the clock but there was still an error contained with*'in'* it as it was showing the wrong time. In order for me to claim that Szasz's ideas should still be considered with regard to improving mental healthcare today, in the rest of this chapter I will aim to prove that these arguments from the 'If/Of' distinction not only fail to disprove Szasz's thoughts about mental disorders but in fact support his assertion that they are greatly impacted by our sociocultural contexts and experiences.

3.2 Critique of the *'In/Of'* Distinction from Hermeneutics

In the first two examples from Graham, concerning the alarm clock and the doorbell, we see scenarios in which objects have not functioned in the way that the user expected, without there being a malfunction *'of'* the objects themselves. For Graham, these objects don't' have errors *'of'* themselves as they are functioning correctly; tracking the time and ringing when pressed. However, errors are still present in the time that the clock shows, and the information contained within the ring of the doorbell. This is because, without the physical substance of the object, there would be nothing to 'display' or 'present' the error *'in'*, without the clock, there would be nothing to display the wrong time and without the doorbell there would be nothing for a squirrel to press. In terms of the mind-brain, without the physical substance of the brain, there would be nothing for a mental disorder to appear *'in'*, even if

there is no error *'of'* the brain itself. However, I believe that Graham misses an important factor in his examples- the part that interpretation plays in our assignment of errors.

The phrase: "the wrong information is contained within the ring" seems to suggest that Graham believes that the ring of a doorbell *itself* contains the information that a person is at the door and therefore, when the doorbell rings, Graham *expects* a person to be at the door (ibid, p.516). Similarly, thinking that the clock is displaying the 'incorrect' time, despite the clock still counting accurately, is only due to a combination of negligence to not change the time, along with the expectation that a clock will always display the right time. In both of these scenarios, it seems that a small mistake (i.e., not changing the time on the clock and a squirrel activating a doorbell) along with the expectation that these objects will function in a certain way, leads to the conclusion that there is an error *'in'* them.

In the case of the alarm clock, Graham's claim that there is an error *'in'* the clock relies on the agreement that there is no mechanical error *'of'* the clock and that the displaying of the wrong time by the clock is an error itself. However, I propose that there is neither an error *'in'* nor *'of'* the clock and instead the error we see is only an error that we assign based on our expectations of the clock, and how we interpret the information it displays. In this case, the error does not belong to the clock, it is neither *'in'* nor *'of'* the clock, rather the error belongs to the person that assigns it to the clock; they interpret that the clock is displaying erroneous information based on their expectations. In fact, a more patient person in this scenario could assign the error to themselves for not changing the clock to reflect the time zone they are in. For this person, the function of a clock is to accurately track seconds, minutes and hours, something the clock is doing perfectly well, we simply expect the clock to show the correct time because we usually set it to the right time for it to carry on tracking. Therefore, our assignment of an 'error' to this clock can be seen as being dependant on our expectation of the clock, rather than because the clock has any inherent 'error' itself.

Similarly, with the doorbell, Graham states that the doorbell is "supposed to" notify the guest that a person is at the door (Graham, 2013, p. 516). However, it is only because we have the expectation that the ring of a doorbell means that there is someone at the door that we see an error. The bell is still functioning perfectly; it rings when it is pressed. It just so happens that it has been pressed by a squirrel, not a person. If we instead see the function of a doorbell as being 'to ring when pressed' then there is no error here. It is only when we expect the doorbell's ring to denote something very specific that we interpret there as being an error.

Errors assigned to objects being determined by the user, rather than being an intrinsic property of the object, could also be exemplified as follows: Two friends have the same old

doorbells outside of their house. One homeowner has an elderly mother who regularly visits. The mother is not very strong and sometimes struggles to press the old doorbell, meaning that the daughter isn't always notified when their mother is outside. Because of this, the homeowner decides to get a new doorbell, one which is more sensitive to being pressed, allowing it to notify them of when their mother visits. They are so pleased with their new doorbell that the homeowner recommends it to their friend in the neighbourhood, who also decides to purchase it. Their friend installs their new doorbell in place of their old one, just to the side of their front door where some ivy grows up on the brickwork. The friend is less than impressed with the new doorbell; when the ivy blows in the wind it causes the bell to chime, even when there is no one at the door, a problem that they never had with their older, less sensitive doorbell. Here we can see two people are using two identical doorbells, but only one assigns theirs an error. The assignment of an error to the old doorbell came from the homeowner with an elderly mother; they expected a doorbell to be able to sense weaker presses than it was able to. The friend with the ivy however never had this issue, everyone they knew was strong enough to press the old doorbell sufficiently enough to make it chime when they were at the door, so it functioned as they expected- it rang whenever pressed by a person. This friend however was less than pleased with the more sensitive doorbell and assigned it an error, as it was sensitive enough to be pressed by their ivy when it was windy. In this case, the doorbell did not fulfil their expectation of only notifying them when people were at the door. In a similar case to Graham's example, the doorbell rang whenever it was pressed even slightly, meaning that it chimed even when it was not pressed by a person. For the homeowner with the elderly mother, however, this new doorbell was perfect. They expected a doorbell to ring when pressed even slightly so they could know when their weaker relatives came to visit. For them, this sensitive doorbell fulfils their expectations and is not erroneous in any way. Here we can see how, as Graham claims, there are no errors *'of'* the doorbells as they are not mechanically malfunctioning but also that two identical doorbells can be seen as having an error for one user but not another. However, I claim that this does not demonstrate that there is an error *'in'* the doorbells, but instead the errors the owners see their doorbells as having are contained within their own expectations which are impacted by their own personal use cases.

The errors *'in'* these objects seem to only be errors when we expect them to function in a certain way and then, due to a mistake, they do not. In fact, a more tolerant person perhaps would not see these examples as demonstrating any errors in objects at all, they may instead see the error as being contained within their own expectations. This leads us to question whether, if there is no detectable error or malfunction *'of'* the objects themselves, and an error only arises because of our expectations about an object, are these

errors *'in'* the objects as Graham proposes, or rather *'in'* our expectations which surround the objects?

Graham's third example regarding the guest's laptop can be seen to raise a slightly different question when looking at it through a hermeneutic lens. In the previous examples, we have seen objects mechanically working as intended (accurately counting time and ringing when pressed) but our expectations of these objects caused us to perceive an error *'in'* them in specific situations. In this example, however, there has *always* been an error in this software; it has never been able to process the word 'Diego' correctly, even before anyone expected it to. In contrast to the clock and the doorbell, the error on the laptop was an error before there was expectation about it, not as a result of expectation. In this case, our expectations do not create the error, but they instead reveal the error that was already there. This example raises the question of whether existing errors are only noticed, or labelled when they begin to defy our expectations.

This third example from Graham parallels Papineau's (1994) Software-Hardware distinction. Papineau states that different computers with different "internal physics" can still run the same programme. For example, an Apple Mac running iOS and a Microsoft Surface laptop running Windows can both run the programme Microsoft Word (ibid, p. 74). Papineau explains that this is possible because although the internal workings of the computers are different, they are "structurally similar" enough for both systems to be able to run the same programme, in that they will respond to inputs in a way that will be physically different in the hardware but will produce the same output of running the software (ibid, p. 74). In analogy, Papineau then goes on to compare the responses of humans and octopuses in pain. When either a human or octopus is in pain, they produce the same 'outputs', namely taking action to reduce and avoid pain. However, for Papineau, there is nothing physically similar in the brains of octopuses and humans when they experience pain, as the "cells and molecules" which respond in these situations are entirely different for either creature (ibid, p. 74). Despite the physical structure of octopus and human brains being different, just as the hardware in a Mac and Surface laptop is different, they still produce the same response to pain- avoidance- just as both computers could run the same programme.

Similarly to Graham, Papineau then moves on to discussing 'errors' in these systems. Papineau asks us to imagine that both computers (which are structurally different) are running the same version of Microsoft Word, and each time their users try to double space a paragraph, the paragraph gets deleted. This demonstrates a problem with the software running on the computers rather than an error of the computers themselves, just as Graham demonstrated a problem with the motel booking software running on a laptop. Rather than

explaining this as an error *'in'* the computers as opposed to *'of'* the computers as Graham does, Papineau claims that this example demonstrates a 'structural' error, rather than a 'physical' error of the computers because both are functioning normally (but physically differently) yet are making the error of deleting paragraphs. Because both computers have different physical systems, Papineau explains that "there is no strictly physical description of what the computer is failing to do", rather the failure is one of a structural nature (Papineau, 1994, p. 76).

Comparing this then to mental disorders, Papineau moves on to claim that a brain's physical state may be 'normal' with "the right molecules, enough neurotransmitters, and so on", but that a person could still experience a mental disorder if they are not experiencing what they are "supposed to", because something structurally, rather than physically, in the brain is "has gone awry" (ibid, p. 76). To exemplify this the mental disorder of OCD is used. Papineau explains that OCD can be seen as a disorder of the 'decision-making system' in our brain, caused by a structural error. Usually, this system would analyse situations and make rational decisions based on the information it processes. However, in the case of OCD, Papineau argues that the person's brain can be physically functioning correctly, but they do not make rational decisions, not because there is an physical error with molecules or neurotransmitters, but because of their compulsions, a structural error, which could be seen as a "bug" in their "decision-making procedures" (ibid, p.76).

Although Papineau is not directly making an *'In/Of'* distinction as Graham is, I still believe that his argument can be subject to the same criticism from hermeneutics, as well as from key mistakes in his examples. Similarly to Graham's example of the laptop and faulty booking software, I believe that Papineau's example actually shows how we assign errors when something defies our expectations. Both users of Microsoft Word on a Mac and a Surface laptop would not have viewed there as being any error until they tried to double space the paragraph which was subsequently deleted. Just as in Graham's example, there has always been this (theoretical) error in the programme; it has always deleted paragraphs instead of double spacing them, it was only when the users happened to use the double space feature that their expectations were defied, and they noticed an error. Again, similarly to Graham, Papineau states that this example demonstrates that these errors aren't physical errors, because both computers which are physically different are experiencing the same error in the software. Here I agree that there are no physical errors in the computers' hardware. However, I disagree that the fact that the two computers being "a PC" and "a Macintosh" makes any difference to the example at all, I also disagree that the example demonstrates a "structural" error of computers themselves (Papineau, 1994, p. 74).

In Papineau's example, we can see that he compares computer hardware to brains, the programmes running on this hardware as the thoughts and feelings we have, and the output of this programme as our actions. Just as there was a 'bug' in the Microsoft Word programme which caused a faulty output despite the computer hardware working well, Papineau suggests there is a 'bug' in a service user with OCD's decision-making process which causes them to make irrational decisions, despite there being no physical problem in the brain. However, I argue that the parallels should be explained as follows: the computer hardware should be seen as the body, the operating system running on the computer should be seen as the brain, the programme can be seen as our brain processes and the programme output as our actions.

Whether a computer is a Mac or a Windows PC, the hardware used within them is extremely similar, all need a battery, a CPU, some RAM etc. Until 2021, when Apple released Macs which run from M1 chip CPUs, both Macs and PCs were running from Intel I-series CPUs, meaning that the hardware in both Macs and PCs wasn't just "structurally similar", but practically identical (Papineau, 1994, p. 74). I believe that Papineau misses the fact that the thing that makes PCs and Macs different is the operating systems that they run as standard, with Macs running MacOS and most PCs running Windows. The operating system manages interactions between a system's hardware and the programmes that it is running. For example, when you want to save a Word Document to your hard drive, the operating system interfaces this interaction from the programme to the hardware. Operating systems may present icons differently or have slightly different names for standard functions, but all allow the system's hardware to interact with programmes installed on it, as well as allowing the user to carry out basic functions such as searching the system, and managing files, etc.

Although Macs and PCs run different operating systems as standard, they are both able to run the opposite operating system, as well as being able to run other alternative operating systems too. This again demonstrates how the systems are practically identical, with far more similarity than Papineau claims. In this way, I see the hardware of a computer as being far more like the body, with physical organs and systems that allow the brain to function, which are extremely similar in most humans. The operating system then parallels our brain, the brain allows the interactions that our physical body has with the world around us to be processed into thoughts and feelings. These thoughts and feelings are then similar to the programmes running on a computer, as they use the brain to 'interface' with a body to produce actions.

Papineau claims that the fact that both a Mac and a PC can run Microsoft Word despite having 'different' hardware demonstrates that when they both experience the same error

with the programme it cannot be due to a physical error. However, I believe that because the internal hardware of computers is far more similar than Papineau claims, the same error occurring in a programme running on both a PC and a Mac could very possibly be caused by the hardware. In parallel to mental disorders, we see that bodies are very similar from person to person but in some situations, a person's body may carry out actions which are different from the actions of other people in the same situation. Mental disorders (errors in thoughts and feelings) can cause a body to perform actions which are not similar to everyone else's, and it is this perceived 'irrationality' that is a key criterion for many mental disorder diagnoses (American Psychiatric Association, 2013, pp. 19-20, 137, 241, 283). Here I agree with Papineau in a sense, this example demonstrates that mental disorders may not be physical, but they need a physical body for symptoms to present themselves in. However, rather than these symptoms or 'errors' having to suggest a 'structural' error in a person, I claim that this example once again demonstrates how our expectations play a crucial role in our assignment of errors. It is only when a person acts notably 'at-odds' with the expectations of those around them that we see there being any 'error' which we can then assign as a symptom of a mental illness. Before a person's actions contravene the expectations of those around them, we do not label them as having any symptoms or assign them any errors. In parallel with Graham's example, before the users tried to double space their paragraph and the programme did not carry out the function as expected, they did not see there as being an error with the programme or computer.

Graham's final two examples concern people, rather than objects, possibly bringing us closer to the mind-brain discussion at hand. In the case of the pregnant woman, we can see how our expectations play a part in how we view her symptoms. If we see someone experiencing nausea and sickness, we will assume they are ill, that there is an 'error' of their biological body, because we expect the majority of people that we interact with to be generally healthy. However, knowing that the woman is pregnant changes our expectations. We may not 'expect' all pregnant women to experience morning sickness, but equally, we don't expect no pregnant women to experience morning sickness. Here, our expectations change because of the context of the situation. Generally, seeing a person experiencing sickness would result in us assuming that there is an error *'of'* their biology. However, when we see a pregnant woman experiencing sickness, we may feel sympathy for her, but we do not see there as being an 'error' '*of*' her biology because, for many, morning sickness is a natural part of pregnancy. This not only exemplifies once again how our expectations play a crucial part in our assignment of errors, but also how the context we have about a situation affects our expectations.

Finally, in the example of the man on a rowboat Graham claims that the error lies *'in'* the "failure" of the man's visual system to "furnish" his brain with the information required to recognise the effect of refraction on the oar (Graham, 2013, p. 517). However, I believe that this example once again links closely to how our expectations and understanding of situations affect how we judge the errors in them. In this example, the man did not understand that his oar was not really bent because he did not have the information to understand the concept of refraction. This led to the 'error' of the man not being able to understand that the oar was straight. We then only assign an error to the man because we expect him to be able to understand refraction.

Human vision has evolved to deal with certain environmental contexts, but seeing things underwater is not one of them. Therefore, we need to compensate for the visual effects of water with interpretation, but we can only do this if we are aware that we need to and know how to do so. If a man identical in every way to the first, apart from this one had knowledge of refraction, was in the exact same situation as the first man but because of his knowledge he did not mistakenly believe the oar was bent, we would not say that there was any 'error' anywhere here. How can we then assign an error *'in'* the first man's visual system and not in the second man's, despite their visual systems being identical? The only difference between the two men was the information available to them and their understanding of the situation they were in. Both men sensed the visual stimulus of the bent oar, both acknowledged that it appeared bent, but the second man understood that this was an illusion created by refraction. In no way did either man's visual system work differently, it was only their understanding of what was processed by their visual systems that differed. Therefore, I do not believe it is accurate to say that there is an error taking place *'in'* a visual system, but rather that we can perceive the first man's understanding of the bent oar as erroneous, only because we process more information about refraction than him. This is not to say that we require a complete understanding of refraction in order to interpret objects under the water more accurately, but only an awareness that the visuals we perceive of underwater objects are inaccurate.

People have been spearfishing for thousands of years, yet Snell's law of refraction was only developed in the early 1600s. People before this did not require an explanation of refractions from Snell's law in order to adjust for refraction. Through trial and error it could be understood that fish were not where they appeared to be in the water, and their aim would need to be adjusted in a particular way in relation to their visual perception in order to catch the fish. It is not only humans who must compensate for refraction without understanding the physics behind it, birds who dive for fish must also have an 'awareness' that their visual perception of the position of fish in the water is inaccurate. Birds don't understand refraction

in terms of the physics behind it, but we do know that they compensate for it because of the angle at which they dive for food. Much like humans, these birds' visual systems have not evolved to take into account refraction, but their behaviour has adapted to compensate for it. Rather than diving straight down into the water when they see a fish, birds dive closer to a right angle as the effect of refraction at this point is much less, so the fish is physically much closer to where it appears visually.

In these cases, we can see that we don't need to fully understand the concept of refraction for us to compensate for it, but it does require previous experience of refraction in order for behaviour to be adapted accordingly. If one person has never experienced refraction before, and another has, they may have identical visual systems which process the information about an oar in the water identically, but it is then the reflection on previous experiences that would allow one to understand that the oar wasn't really bent, leaving the other confused by their visual perception. There is no error in either visual system; both have identical visual perceptions, but one person is able to supplement their visual perception with experience or knowledge. This does not mean that there is an error *'in'* or *'of'* the other's visual system, only that they have not been able to reflect on previous experience or draw on knowledge to compensate for their visual system not correcting the effect of refraction. It is only because we expect people to have knowledge or experience of refraction that we may, like Graham, assign an error to those who do not have such knowledge or experience.

I believe that looking at these expanded examples through a hermeneutic lens can impact the conclusions Graham makes about mental disorders which he uses to argue against Szasz. If it is the case that the errors Graham exemplifies are errors in our expectations, rather than *'in'* an object, then are mental disorders disorders *'in'* the brain (or another physical substance), or instead are they a product of third parties 'labelling' behaviours or habits that do not fit with the expectations of the person themselves (in cases such as visual or auditory hallucinations), or the expectations of wider society (in cases such as phobias and addictions)?

In the case of mental disorders, a person with such a disorder may have no 'errors' *'in'* or *'of'* their brain. Rather, professionals assign disorders ('errors') to service users when they behave in a way that contradicts the clinician's usual expectations for that person. An individual may see themselves as having a mental disorder, but I believe that this again does not constitute an error *'in'* or *'of'* their mind or brain. Instead, they have assigned this error to themselves based on their expectations of themselves. Just as in the case of the alarm clock when our expectations were related to the surroundings (noting importantly that back in another time zone a completely identical clock would not have an error assigned to it

at all), in the case of mental disorders in people, our expectations of someone will be based on the context that they are in as well as our own contexts with will include biases, experience, cultural norms etc.

Medical diagnosis relies on health professionals recognising clusters of bodily problems that have been identified as valid indicators of a particular disease or disorder followed by physical testing to find the dysfunction causing the symptoms or objectively identifiable issues caused by the dysfunction. To identify these clusters as reliable indicators of disease, researchers do not rely on symptoms alone, as symptoms such as pain or nausea and the extent of them are subjective to each patient, based on a sliding scale which is impacted by their previous experiences of such symptoms. Instead, the importance of linking symptoms to bodily processes which can be more objectively identified and monitored, such as blood pressure or oxygen level, is encouraged by medical researchers (Johnstone & Boyle, 2018, p. 21). From these objectively identifiable clusters, researchers work backwards to identify an underlying physical cause. These underlying causes are diagnosed by objectively measurable bodily processes and are then given names such as 'meningitis' or 'pneumonia'. For example, in the case of lung cancer diagnosis, a patient usually presents with the following symptoms: persistent cough, re-occurring chest infections, persistent breathlessness and aches or pains when breathing (National Health Service, 2019b). A doctor of a service user who is presenting with these symptoms may suspect lung cancer, as these symptoms are common signs of the disease. However, before a diagnosis is made the doctor must make a referral for diagnostic tests. The tests for lung cancer usually include a chest x-ray as a preliminary test to understand if there is a mass in the lungs (ibid). Following this patient will receive a CT scan to determine if this mass may be cancerous and if it is determined that a mass may be cancerous a service user is then is offered a form of biopsy to more definitively diagnose the type of cancer they have (ibid).

In contrast, the of majority diagnostic criteria for mental disorders in the DSM-V are reliant on groups of symptoms alone, for example experiences of 'depressed mood', 'diminished interests', 'fatigue', 'feelings of worthlessness' and 'significant weight loss' over a two week period are diagnostic criteria for Major Depressive Disorder (American Psychiatric Association, 2013, pp. 160-161). Unlike physical illnesses, no objectively identifiable causes of these symptoms are required for the diagnosis of mental disorders. Instead, the symptoms themselves, as well as the perceived severity of them, their impact on the service user's daily life, and their longevity are used for a psychiatric diagnosis. Because of this, the diagnosis of a mental disorder requires professionals and service users to make subjective judgements about what someone, or they themselves, might be experiencing, such as 'excessive anger, 'inflated self-esteem' or 'inappropriate guilt' (ibid, pp. 64, 124, 125). Unlike

blood pressure or oxygen levels which can be objectively monitored and used for medical diagnosis, these psychological symptoms are subjective for both patients and clinicians, as they will be affected by the individual's interpretation which is influenced by social and cultural expectations, such as how they have previously reacted and how others around them have reacted in similar scenarios. In acknowledgement of this, the DSM-V requires that symptoms 'differ from sociocultural norms' in order to be considered as mental disorders (ibid, p. 14). However, what is seen as excessive, inflated, inappropriate or ill-fitting with sociocultural norms depends greatly on the context of both the patient and clinician, just as the assignment of errors in Graham's *'In/Of'* distinction examples were greatly dependent upon the person's context and viewpoint. An example of this is clearly demonstrated by Cohen and Nisbett's (1996) Honour Culture study.

Cohen and Nisbett's 1996 study of Honour Culture in the Southern states of the USA demonstrates how context and background can greatly affect how people express and perceive emotions, including those that are used as diagnostic criteria in the DSM-V, such as anger and aggression. In their experiments, Cohen and Nisbett studied the behaviour of 83 white male University of Michigan students, 42 from Northern states of the USA and 41 from Southern states, after they were exposed to an insult. Experiment participants were asked to fill in a form and take it to a room down a narrow hallway. During their walk down the narrow hallway, a person using a filing cabinet would slam a draw shut, bump the participants' shoulders, and call them an "asshole" (Cohen, et al., 1996, p. 948). The reactions of the participants, including their facial expressions, body language and any verbal reactions, were recorded by two observers, acting as students in the corridor. The study found that the two main reactions to the bump and the insult were anger and amusement, with a significant North-South divide. 85% of participants from Southern states reacted angrily to the bump and insult, compared to only 35% of students from Northern states (ibid, p. 949). Following this interaction, participants were asked to complete a 'scenario' task. They were told a story about a man and his fiancée at a party and asked how they would complete the scene. The situation posed to the participants was as follows: a man and his fiancée are attending a party, and the fiancée tells her partner that another man keeps making passes at her despite knowing that she is engaged, shortly after, the partner sees the man try to kiss his fiancée. Mirroring the divide seen in the 'bump and insult' task, 75% of participants from Southern states mentioned actual or threatened violence against the other man in their competition of the scenario, compared to only 41% of participants from Northern (ibid, p. 949).

Cohen and Nisbett concluded that the probable cause of such a North-South divide in terms of violent and aggressive responses is due to a history of a "culture of honour" in Southern

states (ibid, p. 946). Cohen and Nisbett explain that the historical economy of Southern states was based on herding, meaning that cattle being stolen or injured had major economic impacts on individuals. Law enforcement in the South was also described as being "inadequate, corrupt, or just too far away", encouraging individuals to take justice into their own hands (ibid, p. 946). It was therefore preferable for people in the Southern states at the time to have a reputation as being tough or able to defend themselves, even if this meant greeting trivial matters with violence. This is because such aggressive reactions would serve as warnings to the community and discourage anyone from stealing or killing their herds. Nisbet and Cohen label this a culture of defending one's "honor" [sic] (ibid, 946). Although life in Southern states is not as it was when the economy was driven by cattle farming, this culture of defending honour has continued to influence those living in Southern states (ibid, p. 946).

As well as being shown in Nisbett and Cohen's study, this "emphasis on honour and protection" by people in Southern states also can be seen in homicide rates. Homicides committed by white males in Southern states outnumber those committed by the same group in Northern states, but only for homicides related to arguments or conflicts which may challenge a person's "honour", such as disagreements regarding relationships or social standing (ibid, p.946). Homicides relating to other felonies unrelated to honour, such as burglary, had similar rates in both Northern and Southern states. An earlier study by Nisbett and Cohen (1994) also showed that people from Southern states were more approving of certain types of violence compared to those in Northern states, specifically violence used for "self-protection, to respond to an insult, or to socialize [sic] children" (Cohen, et al., 1996, p. 946). This study shows how people have evolved to have their behaviour governed by their localities, and despite modern society possibly being at odds with the conditions in which these localised behaviours developed, they are still prominent in people from these communities today.

The claim that humans are an inherently 'cultural' species, in that we absorb the shared beliefs, customs, rules, norms and expectations of the people around us, and that these cultures vary from community to community is an idea also supported by Boyd & Richerson (2005) and Henrich (2016). The adoption of a culture informs us of how to live and interact with the people around us, as well as identify members that are not a part of our immediate community. The Northern-Southern disparity demonstrated by Cohen and Nisbett's (1996) Honour Culture study is an example of cultural difference, a phenomenon which, by the standards of Boyd, Richerson and Henrich, is endemic because it is central to what and who humans are.

I believe these ideas about culture are clear demonstrations of how our context can affect our own behaviours and our expectations of others' behaviour. In this case, people from the Southern states of the USA are more accepting of aggression and also more likely to behave aggressively, based on the culture of their home state (Cohen, et al., 1996). When looking at this in relation to the diagnostic criteria of the DSM-V we can see how the context of both service users and clinicians can affect a diagnosis. The DSM-V mentions aggression as a diagnostic marker for several disorders, along with related behaviours such as 'temper outbursts' or 'hostility' which must be perceived as 'excessive' or happening with 'little provocation' (American Psychiatric Association, 2013, p. 64, 156, 192, 272, 282). From Cohen & Nisbett's (1996) study we can see that the use of subjective qualifiers such as 'excessive' or 'with little provocation, as well as the symptoms of 'aggression', 'temper outbursts' or 'hostility' themselves can be judged differently based on an individual's context. If a medical professional from a Northern state of the USA was to speak to a service user from a Southern state of the USA, they may interpret some of the service user's behaviours as 'excessively aggressive' in a situation similar to the one that was created in Cohen & Nisbett's study, because participants from Northern states were less likely to approve of aggressive behaviour in response to certain circumstances. However, if this service user from a Southern state was being treated by a professional who was also from a Southern state, their behaviour may not be seen as 'inappropriate' or 'excessive' in a situation similar to that in the Cohen & Nisbett study, which found that the majority of participants from Southern states displayed some form of aggression in response to being bumped into and briefly insulted and were also accepting of aggression in several scenarios (Cohen, et al., 1996, p. 948). We could also see how a medical professional from a Southern State treating a service user from a Northern state could interpret the service user's behaviours in situations similar to those created by Cohen & Nisbett (1996) as symptomatic. The service user's lack of aggression in response to the insult could be perceived as exhibiting 'apathy', a 'lack of self-care' or 'limited (…) emotional responses', whilst the 'amusement' that 65% of participants in the study showed after being bumped and insulted could also be interpreted as happening 'without appropriate stimulus', all of which are diagnostic markers for several disorders in the DSM-V (e.g., American Psychiatric Association, 2013, p. 19, 55, 99, 101, 192, 221). When using symptoms and qualifiers as diagnostic markers for mental disorders, rather than objective tests, the likes of which are used to diagnose physical illnesses, we can see that their subjectivity could lead them to be interpreted differently by professionals and service users depending on their own context and their understanding of the other's context, leading to different diagnoses, be that perceiving different disorders or no disorder at all. Unlike Graham's initial examples which, at worst, could lead to someone booking a motel in the wrong city or arriving to work an hour late, in the case of mental disorders, different

expectations can lead to an incorrect or un-needed diagnosis of a mental health condition, which carries many challenges including stigma, misinformation and unnecessary medical and therapeutic treatments, as discussed in chapter one.

Here we can see, just as we demonstrated when we expanded Graham's *'In/Of'* distinction examples, that depending on our viewpoint, context and understanding of others, we will interpret situations differently and therefore assign 'errors' (or disorders) to 'things' or people differently. Graham used the *'In/Of'* Distinction to argue that there can be errors *'in'* something, but not *'of'* something, namely the brain. However, I believe that when we expand Graham's examples and compare the assignment of errors to objects with the assignment of mental disorders to people, we see that the use of the *'In/Of'* Distinction against Szasz does not sufficiently prove that there can be errors *'in'* something but not *'of'* something. Rather, Graham's *'In/Of'* distinction examples highlight the role that expectation and interpretation plays in our assignment of errors, suggesting that errors are not intrinsic properties '*of*' or '*in'* objects, but instead errors are determined and assigned to objects by people that interact with them. In the case of mental disorders, I argue that Graham's examples do not suggest that there can be errors *'in'* the brain but not *'of'* the brain, but instead, that mental disorders are assigned when people's behaviours defy their own, or our own, expectations.

3.3 Responses to the Criticism from Hermeneutics

Although I have proposed a new element to the *'In/Of'* Distinction, highlighting the part that our expectations play in the interpretation of behaviour and, following from this, the assignment of errors, one could question if this is truly enough to completely disprove Graham and defend Szasz. Simply missing, or just not mentioning, the part that interpretation plays in our assignment of errors does not necessitate that the *'In/Of'* Distinction is completely invalid. For example, perhaps in the case of the clock, we only notice the error of the clock because it defies our expectations, but it only defies our expectations because of the error *'in'* it. Similarly, the error in the motel's booking system had always been there, it could never process the word 'Diego' correctly and it was only when we tried to make it do so that we saw that the system defied our expectations. Perhaps then my addition of hermeneutics to these examples is just *an addition* to the argument, an explanation as to *why* we see the errors *'in'* something, not a point which disproves that these errors exist.

However, I argue that the application of hermeneutics can disprove that errors *'in'* objects are anything more than values which we assign to objects, rather than being an intrinsic value of an object. I believe that the case of the doorbell exemplifies this best. We previously

explored a scenario in which two identical doorbells could be perceived as erroneous by one user and perfectly functioning by another, because of their expectations of the doorbell and the context that affected their use cases. Both doorbells are mechanically functioning as designed, but one user does not like the lack of pressure required to activate the doorbell because it causes an inconvenience when placed next to the ivy growing near their door. For the other user, the pressure required for the doorbell to ring is just right, as it allows their elderly mother to ring the doorbell whenever she visits. Because the two doorbells are identical, and both function mechanically as they were designed to, the error that one user sees in the doorbell cannot be *'in'* or *'of'* the doorbell itself when another identical doorbell is seen as functioning perfectly. Instead, I believe that this example demonstrates how errors are assigned to objects, or people and their minds, by those that interact with them, and the assignment of these errors by others depends on their expectations and interpretations of the object's function or person's actions.

I believe that Graham's errors *'in'* objects are therefore just acknowledgements of the 'thing' we are assigning an error to, without which there would be no error to perceive. For example, in the case of the faulty motel booking software, there is an error *'in'* the software, presumably somewhere in the coding a mistake has been made which processes 'Diego' as 'Francisco'. Here the error is within the software which just happens to run on the computer. Even before the software was running on a computer the error was still there, the computer is just the medium which lets us visualise the error in the software, the computer has no errors *'in'* or *'of'* itself. No matter which computer, tablet or phone the software was running on, the same error would still occur, reinforcing the idea that the error, in this case, is contained within the software and has nothing to do with an error *'in'* or *'of'* a computer, the computer is simply the medium which allows us to visualise an error.

If we consider Papineau's Hardware-Software distinction, the fact that the software could run on many different computers but still make the same error was an apparent exemplification of how a system can have a 'structural' error but not a 'physical' error. However, similarly to Graham, I believe Papineau is mistaken in this claim. Rather than demonstrating that there is an error anywhere in the computer, structurally or physically, I argue that the fact that the software makes the same mistake on different systems demonstrates that the error is contained wholly within the software, and that the computer is simply the system which lets us visualise this error. Therefore, I argue that by hermeneutics demonstrating that errors are extrinsically assigned to objects, rather than being an intrinsic property of them, we can see that Graham's errors *'in'* objects are simply an acknowledgement of the object we are assigning an error to, an object without which we wouldn't interpret an error, despite the object itself containing no errors.

My discussion of responses to the criticism of the *'In/Of'* Distinction here are limited as I have attempted to address possible claims against my criticism through my exemplification of it, as well as being limited by the lack of literature the application of hermeneutics to the *'In/Of'* Distinction. Although my in-depth discussion of my critique would hopefully alleviate any concerns about my claim, it would be my aim to address concerns raised about my critique of the *'In/Of'* Distinction if they were raised in future.

Throughout this chapter, I have aimed to dismiss The Argument from the *'In/Of'* Distinction that is used in attempts to disprove Szasz's ideas about re-framing our understanding of mental health. I have argued that the *'In/Of'* Distinction not only fails to adequately critique Szasz's ideas but that it in fact reinforces Szasz's claims about the influence of sociocultural context and background on what we refer to as mental disorders. Now we are in a position where we have seen that Szasz's ideas from 'The Myth of Mental Illness' are relevant today and can also overcome common arguments used against them, we can consider where Szasz's ideas stand today and how they could impact modern mental healthcare.

Chapter 4: How Can 'The Myth of Mental Illness' Help Improve Mental Healthcare Today?

4.1- Szasz' eliminativism- pre-biology/post-hermeneutics

4.2- How can Hermeneutics help us to reach a new understanding of psychiatry today?

4.1 Szasz's Eliminativism: Pre-Biology and Post-Hermeneutics

The two main arguments that I saw Szasz's 'The Myth of Mental Illness' as facing were 'The Argument from Biology' and 'The Argument from the *'In/Of'* Distinction', both of which I have claimed are not sufficient enough to disprove Szasz's ideas, and instead argue that they both aid his claims. We have discussed that a defence of Szasz's claims regarding a re-framing of mental disorders is still relevant today due to the similar issues to those that inspired Szasz to write 'The Myth of Mental Illness' still impacting mental health service users today and that, if defensible, his ideas could have the potential to positively impact service user care.

Szasz suggested that we re-frame our view of mental disorders, to consider them as 'problems in living', no longer drawing a parallel between mental and physical illness, and instead recognising the impact that sociocultural experience has on mental health, and therefore how subjective the things that we call 'mental disorders' are. As discussed in chapters one and two, the subjectivity of mental disorders comes from both their diagnostic criteria and their method of diagnosis. The diagnostic criteria of the DSM can be seen as subjective as they rely on clinicians to make judgement calls about the extent of a service user's symptoms. These judgements will be based on how a service user's symptoms are viewed in relation to the behaviour of others that the clinician has experienced. Just as deciding your favourite flavour of ice cream is based on how flavours you like and dislike relate to each other on a sliding scale, with the scale changing anytime you try a new flavour. Therefore, the judgement about if a service user's symptoms are 'out of place' enough to not be considered a 'standard reaction' to the life stresses they face, will be centred around what the clinician expects their behaviour should be, and this expectation is based on a clinician's context and previous experiences.

The Argument from Biology takes issue with Szasz's empirical premise: 'mental disorders exist without a physical lesion'. In opposition, proponents of The Argument from Biology claim that there are examples of disorders in the DSM-V which have a physical neurological base, along with pointing out examples of service users who were originally diagnosed with a mental disorder, only to find out that it was a neurological defect that caused the issue.

Both of their claims are quite true, there are several disorders in the DSM-V which have physical bases, mainly under the headings of 'Neurocognitive' and 'Medication-Induced' Disorders and there are also many disorders, such as PANS, which have a physical dysfunction as their cause, but are often initially misdiagnosed as mental disorders, such as OCD or Tourette's, because of the symptoms they cause.

However, proponents of this claim fail to realise that they are re-affirming Szasz's premise that disorders only exist with physical lesions. Szasz argues that what we consider to be mental 'disorders' today should be considered as 'problems in living', with the term 'disorder' reserved for conditions which have a purely physical basis and exist without being influenced by sociocultural context. The fact that someone may have been diagnosed with a condition such as OCD but, after a more thorough investigation from a clinician, it is found to be a neurological dysfunction like PANS, proves Szasz's claim that mental 'disorders' are not caused by physical lesions. This is because the service user never had a mental 'disorder', they actually had a misdiagnosed neurological defect, a physical dysfunction. For Szasz, these misdiagnoses do not mean mental disorders appear with physical lesions, but instead that many of the conditions we consider mental disorders should be re-classified as physically-based neurological disorders, whilst the rest can be classed as 'problems in living'.

If there was a point in medical research where all conditions that we call mental disorders were found to have a physical neurological base, then they could all be reclassified as neurological disorders with objectively detectable diagnostic criteria and clear treatment plans, removing the need for us to consider any condition as a 'problems in living' to avoid misdiagnosis and unnecessary poor treatment. Whilst proving Szasz's claim that all true disorders appear with a physical defect, it would also leave Szasz's ideas about reframing our understanding of mental disorders redundant. However, we are not yet at this stage, we cannot claim that all conditions that we consider mental disorders are caused wholly by physical defects. Therefore, we cannot dismiss Szasz's ideas about re-framing our understanding of mental disorders as 'problems in living'.

Much like the Argument from Biology, the Argument from the *'In/Of'* Distinction also fails to prove that we should dismiss Szasz's ideas regarding mental disorders. The claim that an error or dysfunction can be based or realised *'in'* something but not necessitate that there is an error of dysfunction *'of'* that 'something' misses the impact that our expectations have on our assignment of errors. With a dysfunction *'in'* something actually being an error we assign to an object or person based on it or them not meeting our expectations, rather than there being an error inherently as part of the object or person. In the case of mental disorders, the

'In/Of' Distinction tries to argue against Szasz that there can be a dysfunction *'in'* the brain, causing a mental disorder, without there being a physical dysfunction *'of'* the brain, refuting his claim that disorders can only be present with a physical lesion or dysfunction. I argued that instead, the *'In/Of'* Distinction drew attention to how our assignment of errors, or disorders, is based on our expectations, and these expectations of actions or behaviours are influenced by our sociocultural context and experiences. The study by Cohen and Nisbett (1996) further exemplifies how our expectations are impacted by culture, and therefore how varying mental disorder diagnoses can be based on the sociocultural contexts of both clinicians and service users.

With Szasz's ideas being both relevant to modern mental healthcare, as discussed in chapter one, and defensible against its two main critiques, this leaves us to question how Szasz's argument can impact mental healthcare today. If they are relevant and can be defended, how can the ideas from our discussion of 'The Myth of Mental Illness' potentially positive impact modern mental healthcare?

4.2 How can Hermeneutics help us re-frame our understanding of psychiatry today?

From the discussion that has taken place throughout this paper, I believe that an opportunity has arisen. Not being able to dismiss Szasz's claim that our understanding of mental disorders is mistaken, due to the impact of hermeneutics on the *'In/Of'* Distinction, provides us with an opportunity to re-frame our understanding of mental disorders positively. I propose that considering hermeneutics in a mental healthcare context could allow us to re-frame our understanding of mental disorders in terms of how our expectations and the contextual information we hold about others affects how we interpret behaviour, and therefore how we diagnose and treat mental disorders. Combining Szasz's concerns about the subjectivity of the diagnostic criteria for mental health, with the understanding of the impact that expectations and cultural context can have on our views of others, there is an opportunity to re-frame our understanding of mental health taking these concerns into account.

Why is a new understanding of psychiatry needed?

Just because the inadequacy of the *'In/Of'* Distinction's argument against Szasz has not previously been highlighted through the consideration of hermeneutics, it does not mean that its errors have not always existed, yet psychiatry in the UK may seem to be managing just fine. Recent reviews of mental health services in the UK however, raise concerns over the treatment of service users that access their services (e.g., Department of Health and Social Care, 2021; UK Government, 2018). Although the concerns raised in these reviews may not

be considered as severe as those raised by Szasz when 'The Myth of Mental Illness' was first published, as discussed in chapter two, I believe that our discussion in chapter one highlights that there are still serious concerns regarding mental healthcare in the UK, which at a time when the NHS in England saw a month of people being referred to mental health services every seven seconds, could impact a significant amount of our population (National Health Service, 2021).

In January 2021, the UK Government announced reforms for the Mental Health Act after an independent review in 2018 of The Act set out recommendations for improving mental health legislation. The Department for Health and Social Care's (2021) response to these recommendations acknowledged that although the current Code of Practice 'promotes considerations of a person's dignity and independence, it has not kept up with how society's views of mental health have changed. Specifically, the report identifies that there is a need for 'culturally appropriate advocacy' for service users (UK Government, 2018, p. 58). The review also recommends systematic improvement of mental health services' responses to the ethnic and cultural needs of their locality to improve patient care and outcomes. Here it has been acknowledged that a lack of understanding regarding a patient's background and experiences has led to care which requires improvement. Furthermore, a recently published psychiatric framework by Johnstone and Boyle (2018) cites the contrast between medical and psychiatric diagnosis as a key factor for proposing new ways of framing mental disorders to improve patient care.

As we have discussed in chapter three, medical diagnoses rely on health professionals linking a service user's symptoms to bodily processes which can be objectively identified and monitored. From these objectively identifiable clusters, a diagnosis can then be made. In contrast, the majority of diagnostic criteria for mental disorders in the DSM-V (2013) are reliant on groups of symptoms themselves, not any objectively identifiable causes them, leading medical professionals to need to make subjective judgements about the symptoms a service user is experiencing. In acknowledgement of this, the DSM-V requires that symptoms 'differ from sociocultural norms' to be considered as a mental disorder (ibid, p. 14). However, as demonstrated by Cohen and Nisbett (1996) in their study of honour culture, discussed again in Chapter 3, what is seen as appropriate or inappropriate depends greatly on the sociocultural context of both the patient and clinician, including what their experiences have been and what their own cultural expectations are.

This is acknowledged by the 2018 Review of the Mental Health Act, which recommends that patients should work with 'culturally appropriate' clinicians who have an understanding and awareness of a service user's values and experiences. As if, for example, a person was

seen by a clinician from a very different culture, what may be seen as excessive by the patient or the people around them, may seem acceptable to a clinician, or vice versa (UK Government, 2018, p. 58).

The subjective nature of mental disorder diagnosis based on the guidance of the DSM has also led to several patients being diagnosed differently by separate clinicians, suggesting the possibility of unreliable diagnoses (Kutchins & Kirk, 1997; Regier, et al., 2013). This again links to issues raised by the Mental Health Act review which called for patients to have easier access to a second opinion and greater rights to challenge diagnoses and treatment plans in court (UK Government, 2018).

Furthermore, the latest edition of the DSM, the DSM-V Text Revision (2022b), was edited to include reports about how different "cultural norms" can impact the "perceived pathology" of service users by clinicians and the "risk of misdiagnosis" that a lack of understanding of different cultures can cause (American Psychiatric Association, 2022a, p. 1). Although the DSM-V-TR 'reports' such issues so clinicians are aware of them, there is, as yet, no solution suggested by The American Psychiatric Association to tackle the problems that a lack of awareness of cultural norms and ethnoracial differences can cause. In the next section of this chapter, I will explain how the use of hermeneutics in mental healthcare could potentially alleviate these issues that have only very recently been acknowledged in the DSM, and also help to tackle other issues facing mental healthcare service users that we have previously discussed.

How can Hermeneutics Help?

I propose that hermeneutics could re-frame our views of mental illness and focus on the impact of expectations and their formation on decisions that influence patient diagnosis and care, helping to address some of the recommendations raised in the 2018 review of The Mental Health Act. Viewing psychiatric practice through a hermeneutic lens would bring focus to the part that context plays in setting our expectations of others and ourselves. By understanding how our expectations of others' feelings and behaviours are formed through biases, sociocultural context, experiences etc. we can gain a fuller understanding of how we interpret the behaviour of others and the part this interpretation plays in diagnosing and treating mental disorders. If these questions could be at the forefront of discussions between mental health service users and practitioners, it could encourage them to acknowledge how their expectations affect judgements related to feelings and behaviours and how these expectations have been formed. This hermeneutic thinking will promote exploration into the expectations that clinicians have of service users based on their personal experiences,

biases, and personal and socio-cultural context, as well as promoting discussion of a service user's expectations of themselves based on these factors.

Recently, hermeneutic injustice in psychiatry has been explored in terms of 'marginalised groups' lacking adequate resources for articulating and understanding their own experiences (Spencer, 2021; Stammers & Pulvermacher, 2020). I propose that these ideas can be taken further. The study of hermeneutics can not only highlight the injustices that mental health service users face and encourage new dialogues and frameworks for empowering individuals to communicate their experiences, but I also propose that hermeneutics can be used to re-frame our understanding of mental disorders based on understanding how our expectations of ourselves and others are formed.

A greater mutual understanding of what is expected of a service user and why it is expected may impact the subjective judgements about symptoms that clinicians make to diagnose patients. If a service user has one expectation of their behaviour which is formed due to their socio-cultural context, biases, and past experiences, unless a clinician fully understands these expectations, they may not be able to comprehend why a patient sees their behaviour in a certain way. Similarly, if a clinician does not fully acknowledge what their expectations of a person are and how they have been formed, it may be harder for them to make judgments about the 'inappropriateness' or 'excessiveness' of a person's symptoms as they have little basis for these judgements. Furthermore, if a clinician can understand how both theirs and a service user's expectations are formed, it may influence to what extent they see a service user's symptoms as 'inappropriate' or 'excessive' as they will be able to address biases and assumptions that were not acknowledged before.

Adapting expectations of behaviours has already started to be explored to improve patient care in the field of dementia. A study by Cohen-Mansfield et al. (2015) suggested that the challenging behaviour often seen in patients with dementia was due to difficulty in them expressing their individual needs. This behaviour is distressing for the individual and can be very challenging for carers if it is seen as a 'meaningless' symptom. However, when this challenging behaviour is re-framed as representing the unmet need of an individual, this behaviour becomes 'meaningful'. Therefore, rather than seeing challenging behaviour as purely symptomatic, carers can begin to interpret it as communicative, an understanding that is shown to improve service user care (Cohen-Mansfield, et al., 2015).

Just as Szasz (1960) discussed the 'meaning' of hysteria as a form of nonverbal communication in 'The Myth of Mental Illness', the meaning and use of irrationality and delusions have also begun to be analysed in recent years with conclusions that suggest that building an understanding of their meanings can improve patient care (Bortolotti & Sullivan-

Bissett, 2017). Furthermore, Vintiadis (2016) states that 'rationality plays a big role in what counts as a mental disorder and, hence, in who we judge to have one and how we treat them due to many conditions in the Diagnostics and Statistics Manual (DSM) having 'delusional' or irrational' thoughts as part of their diagnostic criteria (American Psychiatric Association, 2013, pp. 19-20, 137, 241, 283). I propose that increased awareness of hermeneutics in psychiatric practice could be used to aid patients in recognising the external context they have internalised to form expectations of themselves and help them re-frame their behaviours as 'meaningful', as well as aiding our understanding of others' 'irrational' behaviours. If a person sees their behaviour as at odds with expectations of themselves or others' expectations of them, they may feel that there they are acting irrationally. Similarly, if a clinician is presented with a service user who they view as acting at odds with their expectations of people in a similar position, a clinician may view them as acting 'irrationally', a key part of mental disorder diagnosis. However, increased awareness of hermeneutics could provide an impetus for both service users and clinicians to acknowledge their expectations as well as what influenced their formation of them and share these findings. Through this exploration and collaboration, behaviours that were previously seen as 'irrational' to either party could be re-framed as meaningful through contextualisation. Based on the literature discussed, this research could therefore lead to improved patient care and also affect the diagnosis of mental health disorders.

The use of hermeneutics could also aid in meeting new policy aims in the UK by providing a way for a variety of clinicians to provide culturally appropriate care to service users through the recognition of both parties' expectations and how they have been formed. An increased understanding of the context and expectations of the other party may allow clinicians who are of a different sociocultural context to the service users they are interacting with to make more culturally sensitive judgements about diagnosis and treatment. If a service user is also aware of the expectations of a clinician and how they have been formed, they may feel more empowered to ask for a second opinion if they find that their expectations and a clinician's cannot be understood by one another despite collaborative discussion. This again supports the new aims of the Mental Health Act by increasing access and acceptance of service users gaining a second opinion (Department of Health and Social Care, 2021).

In these ways, the critique of the *'In/Of'* Distinction through a consideration of hermeneutics has led us to re-consider Szasz's ideas from 'The Myth of Mental Illness', providing us with an opportunity to acknowledge the impact that context has on our understanding of mental disorders and how the practical application of this acknowledgement could allow us to make improvements to mental healthcare, in line with recommendations from the latest edition of the DSM.

Conclusion

This paper aimed to demonstrate why the ideas from Thomas Szasz's 'The Myth of Mental Illness' (1960) are defensible through a unique criticism of the *'In/Of'* Distinction, and why the key points from both this unique criticism and Szasz's original argument relevant to modern mental healthcare.

I began with a discussion that highlighted the key issues from mental healthcare in the mid-90s that caused Szasz to suggest a new way to understand mental disorders, issues that were clearly demonstrated through Rosenhan's 'Pseudopatient' study. I then introduced the issues that mental healthcare faces today, even after five decades of gradual improvement. I highlighted the issues raised by modern iterations of Rosenhan's study, as well as from reviews of the Mental Health Act, such as unreliable diagnoses, care that infringes service users' human rights, diagnoses that disproportionately affect certain groups, and a lack of appropriate advocacy for service users, mirror the issues that cause Szasz to write 'The Myth of Mental Illness'. I then claim this suggests that, should Szasz's ideas be defensible against their main critiques, there is good reason to revisit them to understand what they offer in terms of potentially improving the care of mental health service users.

Following my explanation of why Szasz's ideas are still relevant to modern mental healthcare, I introduced Szasz's key claim of understanding disorders only as conditions that are caused by physical dysfunctions. Therefore, we should understand mental disorders, which appear without physical dysfunctions, as 'problems in living', acknowledging how much a service user's experiences and context can impact their mental health.

In the latter sections of chapter two, and extensively in Chapter Three, I discussed and critiqued the two main arguments used to argue against Szasz's alternative conception of mental disorders: The Argument from Biology and The Argument from the *'In/Of'* Distinction, finding that both were inadequate to persuade us to dismiss Szasz's ideas. Whilst my critique of The Argument from Biology demonstrated that it did not actually criticise Szasz's ideas, but rather just agree with them from a slightly different perspective, my unique critique of the Argument from the *'In/Of'* Distinction found that common examples used to demonstrate the distinction could actually be seen to support Szasz's argument when discussed through a hermeneutic lens.

I have argued that the *'In/Of'* Distinction failed to acknowledge the impact that our expectations, which are influenced by our context and experiences, have on our assignment of errors, including on our assignment of mental disorders to mental health service users. The five examples used to demonstrate the *'In/Of'* Distinction actually support Szasz's claims about how influenced by context and experiences mental health diagnoses can be by

demonstrating that we assign errors to objects and people when they don't meet our expectations, not when there is something inherently dysfunctional about them. My further critique of these examples also demonstrated that if we were to slightly change the context of the object or person, errors were no longer assigned, showing how our expectations and understanding of errors and disorder are highly influenced by our context. The impact that our context has on our expectations is them further exemplified through the discussion of Cohen and Nisbett's 'Honour Culture' study, demonstrating that our expectations and what we see as acceptable behaviours are clearly influenced by our sociocultural background and experiences. This failure to acknowledge the impact that our expectations have on our assignment of errors meant that, rather that proving an error could occur *'in'* the brain without being an error physically *'of'* the brain, Graham's five examples actually further demonstrated the part that our sociocultural context has on our understanding and diagnosis of mental disorders, just as Szasz claimed.

Having discussed why Szasz's ideas from 'The Myth of Mental Illness' are still relevant today, how two of its main critiques fail to adequately criticise his ideas, and also how looking at the *'In/Of'* Distinction through a hermeneutic lens can actually lead its examples to support Szasz's view, I began to discuss how the ideas from Szasz and my unique critique of the *'In/Of'* Distinction could be used to potentially improve mental healthcare today.

With more people than ever in the UK seeking mental healthcare today, the failures of modern mental healthcare, as outlined by the 2018 governmental review of the Mental Health Act, will affect a much greater proportion of our population. The latest edition of the DSM also reports on how a lack of awareness of ethnoracial differences and cultural norms can lead to different levels of perceived pathology and misdiagnoses, and although this draws clinician's awareness to these issues, there is not yet a way to ensure or encourage the consideration of these factors in clinician and service user interactions. Briefly, I discuss how hermeneutics could promote both clinicians and service users to address biases and understand how their expectations of themselves and each other are formed. As well as this possibly aiding service users to better understand and accept their diagnoses, increased understanding between a service user and clinician has already been seen to improve care and outcomes for service users in cases of dementia. Furthermore, hermeneutics could help address the lack of culturally appropriate care for mental health service users in the UK by allowing service users and clinicians from different backgrounds to understand each other through an open conversation about how their sociocultural contexts affect their expectations of others and themselves.

The extent that hermeneutics can impact mental healthcare in the UK and how it would do so is too great a topic to discuss in this paper as my main focus was to defend and prove the relevance of Szasz's ideas from 'The Myth of Mental Illness' today. Therefore, exploring how a conversational framework based on hermeneutics could be implemented in mental health clinician and service user interactions is my next area of research. Additionally, my suggestion to use hermeneutics in psychiatry stems from my novel argument against the *'In/Of'* Distinction in an attempt to defend Szasz, and although there has been extensive dialogue between proponents of both arguments, I have suggested a new critique which has not yet had the opportunity to be discussed and evaluated. Therefore, my critique's impact on the *'In/Of'* Distinction could vary in the future, affecting the extent to which it could impact mental health service user care, therefore dialogue in this area needs to continue and I welcome discussion and critique of my new defence of Szasz.

Bibliography

Abbott, A., 2019. On the troubling trail of psychiatry's pseudopatients stunt. *Nature,* 574(7780), pp. 622-623.

Aftab, A., 2017. Mental Disorders and Naturalism. *The American Journal of Psychiatry Residents' Journal,* 11(3), pp. 10-12.

American Psychiatric Association, 1968. *Diagnostic and Statistical Manual of Mental Disorders: DSM-II.* 2nd ed. Washington, DC: American Psychiatric Publishing, Inc.

American Psychiatric Association, 1980. *Diagnostic and Statistical Manual of Mental Disoders: DSM-III.* 3rd ed. Washington, DC: American Psychiatric Publishing, Inc.

American Psychiatric Association, 1994. *Diagnostic and Statistical Manual of Mental Disorders: IV.* 4th ed. Washington, DC: American Psychiatric Publishing, Inc.

American Psychiatric Association, 2000. *Diagnostic and Statistical Manual of Mental Disorders: DSM-IV - Text Revision.* 4th-TR ed. Washington, DC: American Psychiatric Publishing, Inc.

American Psychiatric Association, 2013. *Diagnostic and Statistical Manual of Mental Disorders: DSM-V.* 5th ed. Washington, DC: American Psychiatric Publishing, Inc.

American Psychiatric Association, 2022a. *Attention to Culture, Racism, and Discrimination in DSM-5-TR,* Washington, DC: American Psychiatric Publishing Inc.

American Psychiatric Association, 2022b. *Diagnostic and Statistical Manual of Mental Disorders: DSM-V - Text Revision.* 5th-TR ed. Washington, DC: American Psychiatric Publishing, Inc.

Andreasen, N., 2001. *Brave New Brain: Conquering Mental Illness in the Era of the Genome.* Oxford: Oxford University Press.

Arnot, M., Greenwood, E. & Wolpert, M., 2021. How does the British public understand mental health? A qualitative analysis of open-text responses. *International Journal of Social Psychiatry*, 5 October, [Online] Available at: https://doi.org/10.1177/00207640211052174 [Accessed: 30/03/2022].

Baker, C., 2021. *NHS staff from overseas: statistics,* London: House of Commons Library.

Banner, N. & Thornton, T., 2007. The new philosophy of psychiatry: its (recent) past, present and future: a review of the Oxford University Press series International Perspectives in Philosophy and Psychiatry. *Philosophy, Ethics, and Humanities in Medicine,* 2(9), [Online] Available at: https://doi.org/10.1186/1747-5341-2-9 [Accessed 10/01/2022].

Bennet, D. & Morris, I., 1983. Deinstitutionalization in the United Kingdom. *International Journal of Mental Health,* 11(4), pp. 5-23.

Benning, T., 2016. No such thing as mental illness? Critical reflections on the major ideas and legacy of Thomas Szasz. *BJPsych Bulletin,* Volume 40, pp. 292-295.

Bentall, R., 2004. *Madness Explained.* London: Penguin Books.

Black, K., 2005. Psychiatry and the Medical Model. In: E. Rubin & C. Zorumski, eds. *Adult Psychiatry.* 2 ed. Oxford: Blackwell, pp. 3-15.

Blaney, P., 1975. Implications of the Medical Model and its Alternatives. *American Journal of Psychiatry,* 132(9), pp. 911-914.

Bleuler, E., 1911. *Dementia Praecox or the Group of Schizophrenias.* New York: International Universities Press.

Bluhm, R., 2011. Gender differences in depression: Explanations from feminist ethics. *International Journal of Feminist Approaches to Bioethics,* 4(1), pp. 69-88.

Bortolotti, L. & Sullivan-Bissett, E., 2017. How can false or irrational beliefs be useful?. *Philosophical Explorations,* 20(1), pp. 1-3.

Boyd, R. & Richerson, P., 2005. *Not By Genes Alone: How Culture Transformed Human Evolution.* Chicago: The University of Chicago Press.

Broome, M., Fulford, K. & Stanghellini, G., 2004. What can philosophy do for psychiatry?. *World Psychiatry,* 3(3), p. 130–135.

Cahalan, S., 2019. *The Great Pretender: The Undercover Mission That Changed Our Understanding of Madness.* Edinburgh: Canongate Books.

Caplan, A. & Williams, A., 2012. Thomas Szasz: rebel with a questionable cause. *The Art of Medicine,* 380(9851), pp. 1378-1379.

Chen-Wei Ng, C., 2022. Is mind–body dualism compatible with modern psychiatry?. *BJPsych Advances,* Volume 28, p. 132–134.

Clinton, WJ, 1999. *Remarks at the White House Conference on Mental Health,* Santa Barbara: The American Presidency Project.

Cohen, D., Nisbett, R., Bowdle, B. & Schwarz, N., 1996. Insult, Aggression, and the Southern Culture of Honor. *Journal of Personality and Social Psychology,* 70(5), pp. 945-960.

Cohen-Mansfield, J. et al., 2015. Which unmet needs contribute to behavior problems in persons with advanced dementia?. *Psychiatry Res,* 228(1), p. 59–64.

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust, 2022. *What will my assessment appointment be like?.* [Online] Available at: https://www.cntw.nhs.uk/services/first-step/what-will-my-assessment-appointment-be-like [Accessed 23 February 2022].

Cummins, I., 2017. Rereading Rosenhan. *Illness, Crisis and Loss,* 28(1), pp. 38-50.

Department of Health and Social Care, 2021. *Reforming the Mental Health Act,* London: UK Government.

Drescher, J., 2015. Out of DSM: Depathologizing Homosexuality. *Behavioural Sciences,* 5(4), pp. 565-75.

Foucault, M., 1965. *Madness and Civilization: A History of Insanity in the Age of Reason.* English Abridged ed. New York: Vintage.

Glannon, W., 2020. Mind-Brain Dualism in Psychiatry: Ethical Implications. *Frontiers in Psychiatry,* 11(85), pp. 1-4.

Graham, G., 2010. *The Disordered Mind.* London: Routledge.

Graham, G., 2013. Ordering Disorder. In: K. W. M. Fulford, et al. eds. *The Oxford Handbook of Philosophy and Psychiatry.* Oxford: Oxford University Press, pp. 523-529.

Hempel, C., 1965. Fundamentals of Taxonomy. In: *Aspects of Scientific Explanation.* New York: The Free Press, p. 137–154.

Henrich, J., 2016. *The secret of our success: How culture is driving human evolution, domesticating our species, and making us smarter.* Princeton: Princeton University Press.

HM Government, 1964. *Criminal Procedure (Insanity) Act,* London: The National Archives.

How Mad Are You?. 2018. [Film] Directed by N Elkin-Jones, D Grusovin. Austrailia: SBS.

Irving, G. et al., 2019. International variations in primary care physician consultation time: a systematic review of 67 countries. *British Medical Journal Open,* 7(10), [Online] Available at: https://doi.org/10.1136/bmjopen-2017-017902 [Accessed: 20/02/2022].

Johnstone, L. & Boyle, M., 2018. *The Power Threat Meaning Framework: Towards the identification of patterns in emotional distress, unusual experiences and troubled or troubling behaviour, as an alternative to functional psychiatric diagnosis,* Leicester: British Psychological Society.

Killapsy, H., 2006. From the asylum to community care: learning from experience. *British Medical Bulletin,* 80(1), pp. 245-258.

Kingma, E., 2013. Naturalist Accounts of Mental Disorder. In: K. W. M. Fulford, et al. eds. *The Oxford Handbook of Philsophy of Psychiatry.* Oxford: Oxford University Press, pp. 363-384.

Kutchins, H. & Kirk, S. A., 1997. *Making us crazy: DSM: The psychiatric bible and the creation of mental disorders.* New York: Free Press.

Latoo, J. et al., 2021. Mental health stigma: the role of dualism, uncertainty, causation and treatability. *General Psychiatry,* 34(4), pp. 1-4.

Matthews, E., 2013. Mental Disorder: Can Merleau-Ponty Take us Beyond the "Mind-Brain" Problem?. In: K. W. M. Fulford, et al. eds. *The Oxford Handbook of Philosophy and Psychiatry.* Oxford: Oxford University Press, pp. 531-544.

McHugh, P. & Slavney, T., 1998. *The Perspectives of Psychiatry.* Baltimore: Johns Hopkins University Press.

McManus, S., Bebbington, P., Jenkins, R. & Brugha, T., 2016. *Mental health and wellbeing in England: Adult Psychiatric Morbidity Survey 2014,* Leeds: NHS Digital.

Mind UK, 2017a. *Mental health problems – an introduction,* London: Mind UK.

Mind UK, 2017b. *Understanding Mental Health Problems,* London: Mind UK.

Murphy, D., 2006. *Psychiatry in the Scientific Image.* Cambridge, MA: MIT Press.

Murphy, D., 2013. The Medical Model and The Philosophy of Science. In: K. W. M. Fulford, et al. eds. *The Oxford Handbook of Philsophy and Phychiatry.* Oxford: Oxford University Press, pp. 966-986.

Murphy, D., 2020. Philosophy of Psychiatry. *The Stanford Encyclopedia of Philosophy*, 21 September, [Online] Available at: https://plato.stanford.edu/archives/fall2020/entries/psychiatry/ [Accessed: 01/11/2021].

National Archives, 2022. *Asylums, psychiatric hospitals and mental health.* [Online]
Available at: https://www.nationalarchives.gov.uk/help-with-your-research/research-guides/mental-health/ [Accessed 12 February 2022].

National Health Service, 2019a. *Diagnosis- Clinical depression.* [Online]
Available at: https://www.nhs.uk/mental-health/conditions/clinical-depression/diagnosis/ [Accessed 10 February 2022].

National Health Service, 2019b. *Lung Cancer.* [Online]
Available at: https://www.nhs.uk/conditions/lung-cancer/ [Accessed 2 February 2022].

National Health Service, 2021. *Mental Health Services Monthly Statistics, Final September 2021,* London: National Health Service.

National Health Service, 2022. *Mental health assessments.* [Online]
Available at: https://www.nhs.uk/mental-health/social-care-and-your-rights/mental-health-assessments/ [Accessed 23 February 2022].

National Institute of Mental Health, 2019. *PANDAS- Questions & Answers,* Bethesda, MD: U.S. Department of Health and Human Services.

Nesse, R. & Stein, D., 2012. Towards a Genuinely Medical Model of Psychiatric Nosology. *BCM Medicine,* 10(5), [Online] Available at: https://doi.org/10.1186/1741-7015-10-5 [Accessed 20/11/2021].

NHS Digital, 2020. *Appointments in General Practice May 2020,* London: NHS Digital.

Nisbett, R., 2004. *The Geography of Thought: How Asians and Westerners Think Differently and Why.* New York: Simon and Schuster.

North Bristol NHS Trust, 2022. *Psychology First Appointment.* [Online]
Available at: https://www.nbt.nhs.uk/our-services/a-z-services/psychology/psychology-first-appointment [Accessed 23 February 2022].

Novick, A. & Ross, D., 2020. Dualism and the 'difficult patient': why integrating neuroscience matters. *BJPsych Advances,* Volume 26, p. 327–330.

Papineau, D., 1994. Mental disorder, illness and biological disfunction. *Royal Institute of Philosophy Supplements,* Volume 35, pp. 73-82.

Park, A. & Rhead, R., 2013. Personal Relationships. *British Social Attitudes,* Volume 30, [Online] Avalilable at: https://www.bsa.natcen.ac.uk/latest-report/british-social-attitudes-30/personal-relationships/introduction.aspx [Accessed: 25/02/2022].

Parliamentary and Health Service Ombudsman, 2018a. *NHS failing patients with mental health problems,* London: House of Commons.

Parliamentary and Health Service Ombudsman, 2018b. *Maintaining momentum: driving improvements in mental healthcare,* London: House of Commons.

Progler, Y., 2009. Mental illness and social stigma: notes on "How Mad Are You?". *Journal of Research Medical Sciences,* 14(5), pp. 331-334.

Public Health England, 2020. *Prescribed medicines review: summary,* London: Public Health England.

Roberts, R., 2006. Laing and Szasz: Anti-psychiatry, Capitalism, and Therapy. *The Psychoanalytic Review,* 93(5), pp. 781-799.

Rosenhan, 2011. *David Rosenhan: Being Sane in Insane Places* [Interview] (12 June 2011).

Rosenhan, D., 1973. Being Sane in Insane Places. *Science,* 179(4070), pp. 250-258.

Rössler, W., 2016. The stigma of mental disorders. *EMBO Reports,* 17(9), p. 1250–1253..

Ruffalo, M., 2019. *The Rosenhan Study Never Proved Anything Anyway,* Sussex: Psychology Today.

Spencer, L., 2021. *Breaking the Silence: a phenomenological account of epistemic injustice and its role in psychiatry, PhD Thesis,* Bristol: University of Bristol.

Spitzer, R., 1975. More on pseudoscience in science and the case for psychiatric diagnosis. A critique of D.L. Rosenhan's "On Being Sane in Insane Places" and "The Contestual Nature of Psychiatric Diagnosis". *Journal of Abnormal Psychology,* 84(5), pp. 442-452.

Stammers, S. & Pulvermacher, R., 2020. The Value of doing Philosophy in Mental Health Contexts. *Medicine, Health Care and Philosophy,* Volume 23, p. 743–752.

Szasz, T., 1960. The Myth of Mental Illness. *Amercial Psychologist,* Volume 15, pp. 113-118.

Szasz, T., 1972. *The Myth of Mental Illnes: Foundations of a Theory of Personal Conduct Revised Edition.* 2nd ed. New York: Harper & Row.

Szasz, T., 1974. *The Ethics of Psychoanalysis: The theory and method of autonomous psychotherapy.* London: Routledge & Kegan Paul.

Szasz, T., 2011. The myth of mental illness: 50 years later. *The Psychiatrist,* Volume 35, pp. 179-182.

UK Government, 2018. *Independant Review of the Mental Health Act 1983: Modernising the Mental Health Act,* London: UK Government.

Ussher, J., 2011. *The Madness of Women: Myth or Experience.* London: Routledge.

Venters, N., 2018. *The past, present and future of innovation in mental health,* London: NHS Digital.

Ventriglio, A. & Bhugra, D., 2015. Descartes' dogma and damage to Western psychiatry. *Epidemiology and Psychiatric Sciences,* 24(5), pp. 368-370.

Vintiadis, E., 2016. *The Irrationality Within Us. Scientific American.* [Online]
Available at: https://blogs.scientificamerican.com/mind-guest-blog/the-irrationality-within-us/
[Accessed 10 December 2021].

World Health Organisation, 2022. *World Mental Health Report: Transforming mental health for all,* Geneva: World Health Organization.